Fisheries and Oceans / Pêches et Océans

Conservation and Protection / **Conservation et Protection**

Occurrence Report

Occurrence No.: **2000-10431** Case Title: **RIVER OTTER - INJURED WILDLIFE**
DFO File NO.: **0910-00-091** Occurrence Date/Time: **25-Oct-2000 10:00 AM**
Started Date: **25-Oct-2000** Closed date: **25-Oct-2000**
Investigation:

Region: **PACIFIC / PACIFIQUE** Investigated by: **HIGGINS, LINDA # F1672**
Area: **NORTH COAST** Info. Received by: **HIGGINS, LINDA # F1672**
Field Office: **MASSET** Detachment: **HAIDA GWAII (QC ISLANDS)**

Source: **GENERAL PUBLIC - IDENTIFIED**
Fisher Category: **NON-FISHER**
Action Taken: **INVESTIGATION INITIATED**
Occurrence Type: **OTHER LEGISLATION**
Gear Type: **UNKNOWN**
Platform: **VEHICLE**

Fishery: **NOT ON THE LIST**
Management Area: **1**
Water Body:
Port / Community: **MASSET**
Location text: **top of garbage dump hill, approximately 10 km south of Masset**

Latitude: Longitude:
Assigned Officers: **HIGGINS, LINDA # F1672**
MANAGER ZZ INKPEN, JOHN # 1744 25-OCT-2000

Occurrence Note:

F/O HIGGINS was contacted by [redacted] (works at the Masset Recreation Center - 626-5507). She stated that she found an otter on the highway at the top of garbage dump hill. She stopped to pick up the otter for the fur, but it was still alive. She coaxed the otter into a kennel cage with wooden 2x4's. She drove into Masset and phoned the Fisheries and Oceans office. I picked up the otter at approximately 1000 hra. The otter was hissing and breathing heavily. There was blood at the bottom of the cage and on its left side inferior to its front leg. I brought it into the compound and covered the cage.

I contacted C/O James HILGEMANN and notified him of the situation. He suggested I monitor the animal and see if it would recover.

At approximately 1330 hours, I examined the animal and it was worse. There was blood at the bottom of the cage and the animal appeared to have difficulty breathing. I took the otter out to a deserted beach and destroyed it. I notified Sgt. BERNEY of the local RCMP that I had destroyed an animal.

OCCRNC.QRP

Fisheries and Oceans / Pêches et Océans

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Occurrence Report

I notified Garry OTTO that I had discharged my firearm and he asked me to contact Peter WOLOSHYN. I further contacted Brian ATAGI/Chris WILLIAMS as Ritchie RATH, acting pm5, is away.

C/O HILGEMANN took the carcass back to his office.

DFO Investigating Officer:	**HIGGINS, LINDA # F1672**
Officer Address:	**P.O. BOX 99** **1390 OLD BEACH ROAD** **MASSET BC V0T 1M0** **CANADA**

OCCRNC.QRP

From: Jenkins, Randy
Sent: Friday, December 12, 2003 10:52 AM
To: Scott, Kenneth
Subject: FW: Firearms Investigation - Newfoundland

I guess you will participate from this region.

-----Original Message-----
From: Jenkins, Randy
Sent: Friday, December 12, 2003 10:47 AM
To: King, John
Subject: FW: Firearms Investigation - Newfoundland

-----Original Message-----
From: Jenkins, Randy
Sent: Friday, December 12, 2003 10:38 AM
To: Tilley, Stephen
Cc: Farquhar, Mal; Walsh, Jerry; Stevens, Edina; Mercer, John
Subject: RE: Firearms Investigation - Newfoundland

FYI...the attached letter along with the complete Firearms Policy (from intranet site) is being sent to FO [redacted] today via "taxi" that provides service to Burin (Cheeseman's Transportation Ltd).

[redacted]

Randy P. Jenkins
A/Director, Conservation & Protection
Directeur int, Conservation et Protection
Tel: 709 772 4494
Fax: 709 772 3628

-----Original Message-----
From: Tilley, Stephen
Sent: Thursday, December 11, 2003 6:33 PM
To: Jenkins, Randy
Cc: Farquhar, Mal
Subject: Firearms Investigation - Newfoundland
Importance: High

Randy -

Attached are three draft documents. These are provided as samples for the correspondenec that should go to the subject officer prior to the beginning of the forthcoming investigation.

The first letter should go to the subject on Friday (tommorw). It is aletter from you to the subject indicating what the allegations are and that a firearms incident investigation will follw.

[redacted]

The second letter should be mailed so as to arrive no earlier than 30 December and no later than 2 January, 2004. You may have to alter the contents of the sample to reflect any response from the subject offcer.

[redacted]

The thrid document, the Terms of Reference, should be included with the second letter. Please note that the names of the investigators will probably change before the Team is finalised.

Pages 5 to / à 6

are withheld pursuant to section

sont retenues en vertu de l'article

19(1)

of the Access to Information Act

de la Loi sur l'accès à l'information

From: Jenkins, Randy
Sent: Friday, December 12, 2003 8:27 AM
To: Scott, Kenneth; Walsh, Jerry
Subject: FW: Alleged Breach of Firearms policy [redacted]

Sensitivity: Private
Ken,

Can you draft a short BN on this issue that we can send to Mr Follett through channels. Thanks.

Randy
Randy P. Jenkins
A/Director, Conservation & Protection
Directeur int, Conservation et Protection
Tel: 709 772 4494
Fax: 709 772 3628

-----Original Message-----
From: Farquhar, Mal
Sent: Thursday, December 11, 2003 12:12 PM
To: Jenkins, Randy; Tilley, Stephen
Cc: Cuillerier, Paul
Subject: RE: Alleged Breach of Firearms policy [redacted]
Sensitivity: Private

Reference page 100 of the Firearms Policy:

Randy - In the spirit of S. 82 of the firearms policy your RDG should be made aware of these discharges.

Steve - Can you do note from DG to ADM, Legal and Personnel notifying of discharge in accoradance with 82(3)

Mal

Mal Farquhar
Chief, Enforcement Policies, Procedures and Standards/
Chef, Politiques, procédures et normes en matière d'application des règlements
Enforcement Branch/Application des règlements
Conservation &/et Protection
DFO/MPO (613)990-0116
Fax: (613)941 -2718

-----Original Message-----
From: Jenkins, Randy
Sent: Wednesday, December 10, 2003 3:35 PM
To: Cuillerier, Paul; Farquhar, Mal
Cc: Tilley, Stephen

Subject: Alleged Breach of Firearms policy [redacted]
Importance: High
Sensitivity: Private

Good afternoon,

As per earlier conversations please be advised that we have conducted additional "fact finding" into allegations of breaches of the firearms policy [redacted] There are at least two witnesses willing to provide statements to support these allegations (see summary below). The other witnesses may also provide information if formally interviewed. In light of the circumstances and in accordance with the Firearms Policy I respectfully request that an investigation persuant to the Firearms Policy be undertaken. I will assign regional staff (eg. Regional Firearms Officer) to assist in this investigation as required. Please do not hesitate to contact me if further support is required.

Thank you

Randy

-----Original Message-----
From: Lambert, Robert
Sent: Wednesday, December 10, 2003 3:31 PM
To: Jenkins, Randy
Subject: Firearms referral
Importance: High
Sensitivity: Confidential

A Code of conduct investigation began during the week of October 14, 2003, into certain matters involving the conduct of fishery officer [redacted] As a result of information that has come forth during that investigation, further matters not included in the Terms of Reference may require further investigation. Attached is a synopsis of what has been determined to date.

[redacted]

Pages 9 to / à 11

are withheld pursuant to section

sont retenues en vertu de l'article

19(1)

of the Access to Information Act

de la Loi sur l'accès à l'information

From: Jenkins, Randy
Sent: Friday, January 02, 2004 9:48 AM
To: Tilley, Stephen; Scott, Kenneth
Subject: FW: Firearms Investigation [redacted]

-----Original Message-----
From: Jenkins, Randy
Sent: Friday, January 02, 2004 9:47 AM
To: Walsh, Jerry; Mercer, John; Baird, James; King, John; Stevens, Edina
Subject: Firearms Investigation [redacted]

Please be advised the following letter was dropped off in the mail room today to be sent [redacted] "Priority Courier- Signature on Delivery".

[redacted]

The signed TOR was included with the letter.

investigation.tif
(147 KB)

Also attached was a copy of the original letter sent to him on Dec 12, 2003.

[redacted]

Randy P. Jenkins
A/Director, Conservation & Protection
Directeur int, Conservation et Protection
Tel: 709 772 4494
Fax: 709 772 3628

Pages 13 to / à 21

are withheld pursuant to section

sont retenues en vertu de l'article

19(1)

of the Access to Information Act

de la Loi sur l'accès à l'information

To: Fields, Trevor
Subject: Stellar Sealion Put Down

Trevor,
Pursuant to the Firarms Policy, and following my verbal message to you, I am submitting the written report of my actions.

At approximately 11:00 hrs I received a call from [redacted] Gibsons Wildlife Rehabilitatioin Center. He advised me that they had a very sick sealion at Porpose Bay. He was unable to secure a facility that would be able to nurse the animal's health. He asked if I would attend and if need be dispatch the animal.
I attended the location at approximately 1130 hrs. The sealion appeared to be having trouble breathing and moving. Based on unique markings and scars, this sealion appeared to be the same animal that was showing signs of distress when it was hauled out of the water at the Sechelt Indian Band Hatchery last Tuesday, August 24, 2004 (photos taken). Its health was obviously deteriorating since I last observed the animal.
With the evaluation [redacted] it was determied that the animal should be put down to easy its suffering. The Sechelt RCMP were in attendance an blocked off the road for public safety. The Sealion was put down, by me, with one rifled slug that was fired from an approved 12 Guage shotgun. The animal was loaded onto a Sechelt Disrtict truck and is being temporarliy held pending [redacted] inquiries with a biologist to see if there is an interest in an autopsy of the animal. If that fails the animal will be disposed of at the local landfill.
I am also required to send a copy of this report to the Regional Fierarms Officer. I beilive that Brian Atagi is that person, but I am unsure due to various staffing changes. Would you please let me know or forward this report to the RFO? Thank you.

Robert Kaatz
Fishery Officer / Field Supervisor
Madeira Park, B.C.
(604) 883-2313
(604) 883-2152 Fax

Kaatz, Robert

From: Fields, Trevor
Sent: Tuesday, September 7, 2004 11:18 AM
To: Tom Pawloski; Angelo Loggia; Dale Hunt; David Fogtmann; Gary Weighill; Gregory Rahier; Hubert Poschmann; Jeremy Hunt; John Webb; Robert Kaatz; Sandra Lochbaum; Delaney, Paula; Bestwick, Betty; Collins, Gayle; Boyd, Irene; McGowan, Joanne
Subject: FW: Stellar Sea lion Put Down

For your information. This policy is draft but is to be followed.

There were questions came up but conclusions are that Robert's actions were correct.

Trevor Fields
C&P Supervisor
Nanaimo Detachment
phone 250-754-0206
cell 250-616-7333
fax 250-754-0206

-----Original Message-----
From: Kehl, Ron
Sent: September 7, 2004 9:02 AM
To: Fields, Trevor; Paike, Larry
Cc: Lewis, John
Subject: FW: Stellar Sea lion Put Down

Please forward this e-mail with accompanying SOP to the troops.

Ron

-----Original Message-----
From: Atagi, Brian
Sent: Tuesday, September 07, 2004 8:44 AM
To: Kehl, Ron
Subject: FW: Stellar Sea lion Put Down

Brian Atagi
Conservation and Protection | Conservation et Protection
Pacific Region | Région du Pacifique
Fisheries and Oceans Canada | Pêches et Océans Canada
Government of Canada | Gouvernement du Canada
Phone | Téléphone: (604) 666-2187
Facsimile | Télécopieur: (604) 666-4313

-----Original Message-----
From: Atagi, Brian
Sent: Tuesday, September 07, 2004 8:40 AM
To: Lewis, John
Cc: Savard, Greg; Martinolich, Robert
Subject: RE: Stellar Sea lion Put Down

Hi John,

Below is from the Draft "Marine Mammal" SOP on our policy drive.

I believe Robert K. acted within the intent of the following and conducted the events in a safe manner. It would have been prudent to seek the opinion of an actual vet or let the SPCA take the lead (if they operate there). It appears that the rehab centre guy does not have these credentials however he is known in the area and use to be employed by the district. Robert has "worked" with him before. Given this and Robert's previous contact with the sea lion I don't think this is a critical issue. In my mind public safety is the priority and it appears Robert covered this aspect as laid out below and within the requirements of the Firearms policy.

Euthanising Seals, Sea Lions and Elephant Seals

If a seal, sea lion or elephant seal is in obvious distress and if the Fishery Officer feels that it would be the most humane action, the Fishery Officer may choose to euthanise the animal. Please note that a watery, strong smelling stool is common in marine mammals. Marine mammals also tend to dehydrate quickly out of water and begin to lose metabolic water, which leads to weight loss and a lack of muscle tone. Beached seals may have cracked skin filled with pus caused by marine parasites, this is not a serious problem. Multiple skin lesions or small bleeding wounds along the back, rear and flippers may have been caused by breeding or territorial fighting.

Where practical, a licensed veterinarian must be consulted before an animal is euthanised. This may not be possible in remote areas.

If the animal has to be euthanised, the action shall be carried out in a manner that is designed to dispatch it as quickly and painlessly as possible.

Ensure that any spectators or bystanders are removed from the area before euthanising the marine mammal.

Inform the local police, before discharging a firearm in a restricted shooting area.

In an area where discharging a firearm is restricted, the local police shall be previously advised prior to euthanising the marine mammal.

Fishery Officers will not dispatch a marine mammal unless the Fishery Officer has a weapon of adequate calibre, appropriate type of ammunition and a level of skill that will ensure that the marine mammal is euthanised in a safe and humane manner.

Fishery officers are required to dispatch marine mammals at a range of no greater than 25 metres.

At point blank range, seals, sea lions and elephant seals should be shot just above and in front of the ear.

At distances less than 25 metres, seals, sea lions and elephant seals should be shot at the base of the skull, where it joins the vertebral column. For seals the ear opening provides a good target and for sea lions aim just behind the ear.

RDG Memo -
Sealion dispatch...

Enclosed is the draft of the BN for your info.

Cheers,

Brian Atagi
Conservation and Protection | Conservation et Protection
Pacific Region | Région du Pacifique
Fisheries and Oceans Canada | Pêches et Océans Canada
Government of Canada | Gouvernement du Canada
Phone | Téléphone: (604) 666-2187
Facsimile | Télécopieur: (604) 666-4313

-----Original Message-----
From: Lewis, John
Sent: Friday, September 03, 2004 3:31 PM
To: Atagi, Brian
Subject: FW: Stellar Sea lion Put Down

Brian -

I definitely recall a policy document on this. As to whether or not I can find it...is another issue. Everything I own is in boxes. Appreciate any light you can shed on this as this issue is becomming all too frequent.

John Lewis
Area Chief
Regulatory Affairs
Central Coast Area
(250) 902-0629 (office)
(250) 287-6771 (cell)
mailto:Lewisjo@pac.dfo-mpo.gc.ca

John Lewis
Chef de Secteur
Affaire de la Réglemantaire
Secteur Côte-Central
250-902-0629 (bureau)
250-287-6771 (cell)

-----Original Message-----
From: Fields, Trevor
Sent: Friday, September 03, 2004 3:06 PM
To: Kehl, Ron; Lewis, John
Cc: Kaatz, Robert; Atagi, Brian; Tom Pawloski; Angelo Loggia; Dale Hunt; David Fogtmann; Gary Weighill; Gregory Rahier; Hubert Poschmann; Jeremy Hunt; John Webb; Robert Kaatz; Sandra Lochbaum
Subject: RE: Stellar Sea lion Put Down

One of joys of being a fishery officer is that you often have to make decisions and there isn't time to refer to policy if in fact there is a policy. I notice that both of you say you think this is the policy but you're not sure. Brian advised Robert (after the fact I admit) that a policy was coming down but not here yet (I hope I got that right).

Robert was not aware that there is a policy. He had observed this same animal 5 days previously and had seen a complete deterioration in ability. The SPCA guy is well known to Robert as they have worked together in the past

and he has complete confidence in his judgment. In Roberts judgment there was no question that this animal was near death.

Next time Robert well get a vet to approve prior to any action.

By way of this email I am instructing all of my staff that in the event they are requested to put an animal down and they can't get out of it that they are to consult a veterinarian prior to acting.

Trevor Fields
C&P Supervisor
Nanaimo Detachment
phone 250-754-0206
cell 250-616-7333
fax 250-754-0206

-----Original Message-----
From: Kehl, Ron
Sent: September 1, 2004 2:17 PM
To: Lewis, John
Cc: Fields, Trevor
Subject: RE: Stellar Sea lion Put Down

Good point and I do believe that is the policy. Over to Trevor to follow up - perhaps on this one we should let sleeping dogs (sea lions) lie.

Ron

-----Original Message-----
From: Lewis, John
Sent: Wednesday, September 01, 2004 2:00 PM
To: Kehl, Ron
Subject: RE: Stellar Sea lion Put Down

Thanks Ron. I haven't had my eyes on the policy on dispatching marine mammals lately...but I seem to recall that ... weren't we supposed to have a vet verify the mm is ill prior to dispatch?

John Lewis
Area Chief
Regulatory Affairs
Central Coast Area
(250) 902-0629 (office)
(250) 287-6771 (cell)
mailto:LewisJo@pac.dfo-mpo.gc.ca

John Lewis
Chef de Secteur
Affaire de la Réglemantaire
Secteur Côte-Central
250-902-0629 (bureau)
250-287-6771 (cell)

-----Original Message-----
From: Kehl, Ron
Sent: Wednesday, September 01, 2004 1:54 PM
To: Lewis, John
Subject: FW: Stellar Sea lion Put Down

I'll begin sliding some of these your way, for the remainder of the week, just to keep you informed.

-----Original Message-----
From: Atagi, Brian

Sent: Wednesday, September 01, 2004 9:54 AM
To: Fields, Trevor
Cc: Kaatz, Robert; Kehl, Ron; Collins, Gayle
Subject: RE: Stellar Sea lion Put Down

I'm still "it"...

I will start a briefing note to the RDG.

Thanks,

Brian Atagi
Chief | Chef,
Recruitment, Training & Standards | Recrutement, Formation et normes
Conservation and Protection | Conservation et Protection
Pacific Region | Région du Pacifique
Fisheries and Oceans Canada | Pêches et Océans Canada
Government of Canada | Gouvernement du Canada
Phone | Téléphone: (604) 666-2187
Facsimile | Télécopieur: (604) 666-4313

-----Original Message-----
From: Fields, Trevor
Sent: Tuesday, August 31, 2004 1:50 PM
To: Atagi, Brian
Cc: Kaatz, Robert; Kehl, Ron; Collins, Gayle
Subject: FW: Stellar Sea lion Put Down

I believe you are still "it".

If not please forward.

Gayle, hard copy to file please.

Trevor Fields
C&P Supervisor
Nanaimo Detachment
phone 250-754-0206
cell 250-616-7333
fax 250-754-0206

-----Original Message-----
From: Kaatz, Robert
Sent: August 30, 2004 1:05 PM
To: Fields, Trevor
Subject: Stellar Sea lion Put Down

Trevor,
Pursuant to the Firearms Policy, and following my verbal message to you, I am submitting the written report of my actions.

At approximately 11:00 hrs I received a call from [redacted] Gibsons Wildlife Rehabilitation Centre. He advised me that they had a very sick sea lion at Porpoise Bay. He was unable to secure a facility that would be able to nurse the animal's health. He asked if I would attend and if need be dispatch the animal.
I attended the location at approximately 1130 hrs. The sea lion appeared to be having trouble breathing and moving. Based on unique markings and scars, this sea lion appeared to be the same animal that was showing signs of distress when it was hauled out of the water at the

Sechelt Indian Band Hatchery last Tuesday, August 24, 2004 (photos taken). Its health was obviously deteriorating since I last observed the animal.
With the evaluation [redacted] it was determined that the animal should be put down to easy its suffering. The Sechelt RCMP were in attendance an blocked off the road for public safety. The Sea lion was put down, by me, with one rifled slug that was fired from an approved 12 Gauge shotgun. The animal was loaded onto a Sechelt District truck and is being temporarily held pending [redacted] inquiries with a biologist to see if there is an interest in an autopsy of the animal. If that fails the animal will be disposed of at the local landfill.
I am also required to send a copy of this report to the Regional Firearms Officer. I believe that Brian Atagi is that person, but I am unsure due to various staffing changes. Would you please let me know or forward this report to the RFO? Thank you.

Robert Kaatz
Fishery Officer / Field Supervisor
Madeira Park, B.C.
(604) 883-2313
(604) 883-2152 Fax

s.19(1)

Protected

MEMORANDUM FOR THE DIRECTOR GENERAL

DISPATCH OF BADLY INJURED STELLAR SEA LION

(Information Only)

SUMMARY

- Fishery Officer dispatches a badly injured stellar sea lion near Sechelt on August 30, 2004.

Background

- Fishery Officer Robert Kaatz received information from the Gibson's Wildlife Rehabilitation Centre regarding a badly injured sea lion.

- Officer Kaatz proceeded to Porpoise Bay and recognised the animal as one that was showing signs of distress on August 24 at the Sechelt Band Hatchery.

- As the suffering animal was deteriorating and there were no facilities available to take in the animal, it was concluded, in consultation with [redacted] the Gibson's Wildlife Rehabilitation Centre to dispatch the sea lion.

- The animal was put down with a single round from a departmental 12 ga. shotgun. The carcass is being temporarily held pending interest in a post mortem examination. If there is no interest the carcass will be taken to the local landfill.

- Sechelt RCMP detachment is aware of the incident and had an officer in attendance to assist with public safety.

- As per the National Firearms Policy and Procedures, the Regional Firearms Officer, Brian Atagi was notified August 31, 2004. Officer Atagi has informed Gérald Poirier, A/Director of Enforcement at NHQ.

- Section 85 (1)of the National Firearms Policy and Procedures states:
  Where a Regional Director-General is made aware that a Fishery Officer or a DFO employee engaged in law enforcement made threats involving a firearm, has engaged in violent behaviour with a firearm, or has discharged any firearm, and, in the apparent circumstances, it would be reasonable, responsible, and professional to ensure whether or not
  (a) there was a contravention of any provision of this Policy,
  (b) there was a contravention of any firearms control legislation, or
  (c) current training, policy or procedures relating to firearms are adequate,
  that Regional Director-General shall, as soon as possible, request that the Director of Enforcement assemble a Level II Firearms Incident Investigation Team.[52]

Analysis / DFO Comment

- It is recommended that a request under section 85 (1) is not necessary at this time as it appears that the officer's actions were consistent with this policy and training provided to Fishery Officers.

Greg Savard
Director, Conservation and Protection

Brian Atagi/

To:
À:

Date:

Subject:
Objet: **PC Docs: Dispatch of Sea Lion**

From/De: P. B. Macgillivray

Via: Chris Dragseth

[ ]	For Signature/Pour Signature Votre signature	[x]	Information
[x]	For Comments/Pour commentaries Observations	[ ]	Material for the Minister/Documents à l'intention du minister

Remarks:
Remarques :

DISTRIBUTION
Mr./M. G. Savard
Mr./M B. Atagi
Ms/M C. Van Horne
Mr./M. D. Radford
Mr./M R. Kadowaki

Drafting Officer / Rédacteur : Brian Atagi 604-666-2187

Stellar Test Results#1

Stellar Test Results#2

Stellar Test Results#3

Stellar Test Results#4

Stellar Test Results#5

Stellar Test Results#6

Stellar Test Results#7

BRITISH COLUMBIA

ANIMAL HEALTH CENTRE

AAVLD - Accredited Laboratory

Ministry of Agriculture, Food and Fisheries
1767 Angus Campbell Road
Abbotsford BC V3G 2M3
Telephone: (604) 556-3003
Facsimile: (604) 556-3010
Toll-Free: 1-800-661-9808

Case Report

Submission #: 2004-02867 **Date Received** 31-Aug-2004 **Report Dat** 07-Sep-2004

		Report To	Copies To
Submitter: 8019	Gibsons Wildlife Renab Centre	☐	
Owner: 8019	Gibsons Wildlife Rehab Centre	☑	
Farm:			
Vet Clinic: 2901	Vancouver Aquarium		☑
Attending Vet:	Dr. Huff		

Specimen: Whole Animal **Flock Herd Size:**
Species: Marine Mammal, Not Specified **Age:**
Breed: California Sea Lion **Sex:** Female(s) - NOS

Feed: **Feed Supplier:**

Vaccination:

Treatment:

Diagnosis:

1 Myopathy
2 Septicemia

S.A. Raverty, D.V.M.,
Veterinary Pathologist

s.19(1)

Submission #: 2004-02867 **Case Report**

History/Symptoms

Submitted one California Sea Lion for post mortem.

Found on grass park at West head of Sechelt Inlet (Porpoise Bay).

Gross Pathology

A subadult female California sea lion is presented dead, Aug. 31, 2004 in good body and moderate post mortem condition. There are adequate subcutaneous and visceral adipose stores and the animal is well muscled. The stomach is empty and there is a small amount of ingesta multifocally within the intestines. Throughout the distal limits of all lung lobes, there is multifocal to coalescing pulmonary edema and congestion. There are no other apparent gross internal or external lesions.

COMMENTS:

Elective euthanasia was conducted to distress exhibited by this animal. There are no overt lesions within the examined carcass which may account for the antemortem clinical signs of dyspnea and lethargy. Further evaluation is pending histopathology and ancillary studies.

GROSS DIAGNOSES:

1). Lung: Edema and congestion, moderate, multifocal to coalescing, acute

PENDING:

Histopathology
Aerobic and viral culture
Trace mineral analysis
Gross photos obtained
Blood sample for Brucella

Parasitology

Negative for parasites.

Bacteriology

See attached sheets.

* Results faxed Sept. 8/04.

s.19(1)

Submission #: 2004-02867 **Case Report**

Histopathology

1). Heart: Fibrosis, marked, multifocal, plexiform, chronic with replacement and entrapment of myocardial fibres
2). Lung: Bronchopneumonia, marked, multifocal to coalescing, fibrinosuppurative, subacute
3). Kidney: Pyelonephritis, mild, multifocal, lymphocytic, subacute
4). Kidney, medulla: Intratubular mineral deposition, moderate, multifocal
5). Kidney: Nephritis, interstitial, mild, multifocal, random, subacute, lymphocytic
6). Urinary bladder: Cystitis, mild, multifocal, lymphoplasmacytic, chronic
7). Lymph node: Hyperplasia, mild to moderate, diffuse
8). Mammary gland: Mastitis, moderate, multifocal, necrotizing, subacute
9). Stomach, submucosa: Granuloma, moderate, multifocal, random, chronic with intralesional parasitic remnants
10). Tongue, muscularis: Myositis, mild to moderate, multifocal, lymphoplasmacytic, subacute with rare intrasarcoplasmic protozoal parasites morphologically consistent with Sarcocystis spp

There are no significant lesions within the heart, peripheral vasculature, peripheral nerves, adipose tissue, skeletal muscle, salivary gland, trachea, esophagus, diaphragm, liver, thymus, pancreas, colon, small intestine, stomach, thyroid gland, ovary, uterus and Fallopian tube.

Toxicology

See attached sheets.

Final Comments

Although the proximate cause of antemortem clinical signs in this animal are attributed to the multisystemic inflammatory infiltrate, the myocardial fibrosis may have contributed significantly to debilitation and predisposition of this animal to infection. Light to moderate growth of Edwardsiella tarda with smaller and more variable numbers of Escherichia coli, and alpha hemolytic Streptococcus spp from multiple internal viscera. The bacteria, E. tarda is a recognized component of the intestinal flora with clinical disease usually manifested as gastroenteritis or septicemia and secondary to immunosuppression or debilitation. The intratubular mineral deposition is an incidental finding likely associated with dehydration. The gastric submucosal (nematode or roundworm) and lingual (tongue protozoa) parasitism are considered pathologically significant. The protozoal parasites are distinct to the Sarcocystis neurona as documented in sea otters in California and harbour seals in Washington state. No parasites identified by fecal floatation and trace mineral and vitamin A analysis proved within normal in house reference limits.

/bb

s.19(1)

BRITISH COLUMBIA

ANIMAL HEALTH CENTRE

AAVLD - Accredited Laboratory

Ministry of Agriculture, Food and Fisheries
1767 Angus Campbell Road
Abbotsford BC V3G 2M3
Telephone: (604) 556-3000
Facsimile: (604) 556-3010
Toll-Free: 1-888-221-8998

Bacteriology Results

Submission #:	2004-02867	Owner:	Gibsons Wildlife Rehab Centre
Date Received:	31-Aug-2004	Submitter:	Gibsons Wildlife Rehab Centre
Date Completed:		Fax:	604-886-4080 Phone: 604-886-4889
Pathologist:	S.A. Raverty, D.V.M.,	Farm:	
		Location:	GIBSONS
Species:	Marine Mam	Vet Clinic:	Vancouver Aquarium
Breed:	California Sea	Fax:	604-659-3400 Phone: 604-659-3468
Age:		Attending Vet:	Dr. Huff

Preliminary Date: 02-Sep-2004 Completed Date: 03-Sep-2004

lymph nodes -

1+ Edwardsiella tarda
- S ENROFLOXACIN
- S EXCENEL (CEFTIOFUR)
- S Gentamicin
- S Neomycin
- S Amp-Sulbactam
- S Sulfa-methox-trimeth
- S Tetracycline
- S FLORFENICOL

FAXED
SEP 08 2004
Page ____ of ____

2+ Streptococcus alpha-hemolytic

2+ Streptococcus non-hemolytic

lung -

few Bacillus sp.

few Edwardsiella tarda

few Streptococcus alpha-hemolytic

brain -

few Bacillus sp.

2+ Edwardsiella tarda

few Escherichia coli
- S ENROFLOXACIN
- S EXCENEL (CEFTIOFUR)
- S Gentamicin

s.19(1)

Submission #: 2004-02867 **Bacteriology Results**

few **Escherichia coli**

- S Neomycin
- S Amp-Sulbactam
- S Sulfa-methox-trimeth
- S Tetracycline
- S FLORFENICOL

2+ **Streptococcus alpha-hemolytic**

mammary glands -

spleen -

few **Edwardsiella tarda**

few **Streptococcus alpha-hemolytic**

kidneyt -

few **Bacillus sp.**

1+ **Edwardsiella tarda**

1+ **Streptococcus alpha-hemolytic**

colon -

1+ **Edwardsiella tarda**

few **Streptococcus alpha-hemolytic**

small intestine -

few **Edwardsiella tarda**

Comments

No bacteria isolated from mammary gland
No Salmonella found.
Completed by H. Gannon

BRITISH COLUMBIA

ANIMAL HEALTH CENTRE

AAVLD - Accredited Laboratory

Ministry of Agriculture, Food and Fisheries
1767 Angus Campbell Road
Abbotsford BC V3G 2M3
Telephone: (604) 556-3000
Facsimile: (604) 556-3010
Toll-Free: 1-800-661-9569

Toxicology Laboratory Results

Submission #:	2004-02867	Owner:	Gibsons Wildlife Rehab Centre
Date Received:	31-Aug-2004	Submitter:	Gibsons Wildlife Rehab Centre
Date Completed:		Fax: 604-886-4999	Phone: 604-886-4999
Pathologist:	S.A. Raverty, D.V.M.,	Farm	
		Location:	GIBSONS
Species:	Marine Mamm	Vet Clinic:	Vancouver Aquarium
Breed:	California Sea	Fax: 604-658-3469	Phone: 604-659-3468
Age:		Attending Vet:	Dr. Huff

Test Sequence: **Toxi Samples:** 3

Date Received: 31-Aug-2004 **Preliminary Date:** **Completed Date:** 09-Sep-2004 BK

Sample# Description **T-Code**

		Ext Ref	AL	BUN	CA	CAS	OD	OU
1	liver		491		57		2	37.6
2	kidneys							
3	Vitreous humour			9.5		6.9		

		Ext Ref	FE	HG	MG	MN	P	PB
1	liver		133		152	4.7		< 2
2	kidneys							
3	Vitreous humour						6.7	

		Ext Ref	PL	RPL	SE	ZN		
1	liver		159	278	27.99	94		
2	kidneys							
3	Vitreous humour							

Submission #: 2004-02867 **Toxicology Laboratory Results**

Test Type Legend					
AL = Vitamin A (mcg/g)	BUN = Blood urea nitrogen (mg/dl)	CA = Calcium (ppm)
CAS = Calcium (mg/dl)	CD = Cadmium (ppm)	CU = Copper (ppm)
FE = Iron (ppm)	HG = Mercury (ppm)	MG = Magnesium (ppm)
MN = Manganese (ppm)	P = Phosphorus-Inorganic (mg/dl)	PB = Lead (ppm)
RL = Retinol (mcg/g)	RPL = Retinyl palmitate (mcg/g)	SE = Selenium (ppm)
ZN = Zinc (ppm)		

Comments

Normal seal liver mineral levels are:
Selenium 0.45-5.00 ppm Copper 4.0-25.0 ppm
Zinc 80-80 ppm Iron 150-1000 ppm
Manganese 1.0-8.7 ppm Lead <1.0 ppm
Cadmium <0.02-1.00 ppm Calcium 20-100 ppm
Magnesium 120-230 ppm Mercury <0.1-2.0 ppm.

Liver vitamin A results are reported as the sum of retinol + retinyl palmitate and adjusted to a dry weight basis, in order to correspond with published interpretive data.

Normal levels of vitamin A in seal livers fall in the range of:
200-3500 mcg/g dry weight.
The significance of levels below 100 mcg/g dry weight is unknown.

Enquête sur la décharge d'une arme à feu survenue à Gaspé le 26 mars 2008

Enquêteurs :

Charles Cormier
Superviseur de terrain
Instructeur Armes à feu
MPO- Région du Golfe

Marc Naud
Préposé régional aux armes à feu
Chef, Programme de planification et analyses
MPO – Région du Québec
Responsable de l'enquête

22 avril 2008

Mandat de l'enquête :

Suite aux discussions entre le directeur général, Conservation et protection de l'Administration centrale Nationale, M. Paul Steele, et le directeur Conservation et protection de la Région du Québec, M. John Chouinard, il a été conclu qu'une enquête sur la conduite de l'agent des pêches [redacted] le 26 mars 2008 était nécessaire.

Les évènements ayant fait l'objet de l'enquête sont :

- Le 26 mars 2008 vers 08h00, alors qu'il se trouvait dans les bureaux du MPO au 120 rue de la Reine à Gaspé, l'agent [redacted] a déchargé son pistolet de service en contravention aux dispositions de la ***Politique et des procédures sur les armes à feu du Ministère***.

CADRE DE RÉFÉRENCE :

Enquêter sur les allégations et les rapports concernant la conduite de l'agent des pêches [redacted] qui aurait contrevenu aux dispositions de la *Politique sur les armes à feu.*

L'agent [redacted]

a) aurait déchargé une arme à feu de manière illégale, dangereuse, irresponsable ou non professionnelle;	*9 (1) f)*
b) n'aurait pas traité l'arme à feu comme si elle était chargée;	*32 (1) a)*
c) aurait placé le doigt sur la détente alors qu'il ne s'apprêtait pas à tirer;	*32 (1) c)*
d) aurait contrevenu aux dispositions de la Politique;	*35 b)*
e) aurait déchargé une arme à feu du Ministère sans se conformer aux dispositions de la Politique;	*69.1 (1)*
*f) n'aurait pas tenu le doigt éloigné de la détente et hors du pontet comme l'exige le document « **Pistolet de service – Directives de chargement et de déchargement** »*	*Section 1 et Section 2*

PROCÉDURES

L'enquête a été menée par une équipe d'enquête sur un incident lié à l'utilisation d'une arme à feu composée des personnes ci-dessous :

Marc Naud	Préposé régional aux armes à feu - Région du Québec (chef d'équipe)
Charles Cormier	Instructeur Armes à feu - Région du Golfe

Déroulement de l'enquête :

Afin d'obtenir toutes les informations possibles sur les circonstances de l'incident de tir, les enquêteurs ont rencontrés tous les agents des pêches présents dans la section C&P du bureau du MPO à Gaspé le 26 mars 2008 entre 07h30 et 09h00. Les agents des pêches rencontrés ont été : [redacted] Les enquêteurs ont ensuite rencontrés l'agent des pêches [redacted] impliqué dans l'incident de tir.

Les enquêteurs n'ont pas jugés nécessaire de rencontrer le personnel administratif qui était présent lors de l'incident de tir puisqu'elles ont entendu le coup de feu mais n'ont pas eu accès à la salle des armes et n'ont pas été témoin des événements qui ont suivi immédiatement l'incident.

De plus, les enquêteurs ont transmis l'arme impliquée dans l'incident de tir aux armuriers de la GRC pour expertise. Plus précisément, les vérifications suivantes ont été requises :

1- S'il est possible de faire feu avec cette arme en actionnant uniquement la culasse ;
2- S'il est possible de faire feu avec cette arme en appuyant sur la gâchette et en actionnant la culasse simultanément ;
3- Si cette arme est correctement assemblée.
4- Si cette arme présente un défaut mécanique qui expliquerait le tir accidentel lors du chargement de l'arme.
5- D'effectuer toute vérification que vous jugerez pertinente pour nous informer sur les raisons probables de ce tir accidentel.

Pour des raisons hors du contrôle des enquêteurs (Manifestation de pêcheurs interdisant l'accès au bureau du MPO les 22 & 23 avril 2008), la salle des armes (le lieu de l'incident) n'a pu être visité que brièvement le 22 avril en soirée, en l'absence des employés du bureau. Les entrevues avec les témoins de l'événement et l'agent des pêches concernés se sont déroulées le 22 avril 2008 de 08h00 à 12h00 à l'Hôtel des Commandants, salle Guy-Fortier.

Entrevues avec les témoins :

Premier témoin

Au moment de l'incident, l'agent des pêches pour le détachement de Gaspé-Nord.

Début de l'entrevue – 08h15.

Les enquêteurs demandent à l'agent de décrire en détail et au meilleur de sa mémoire les circonstances de l'incident de tir survenu le 26 mars vers 08h10 au bureau de Gaspé :

Agent

- J'étais à mon bureau. La salle d'arme est de l'autre côté du mur. Le cabinet de rangement des armes est sur le mur opposé. Le puits de déchargement est fixé au mur extérieur au fond de la salle (L'agent trace un schéma de l'organisation des lieux).
- J'entends un bruit sourd « BOUFF ». Dans ma tête, c'est quelque chose de lourd qui vient de tomber. J'avais vu aller chercher son ceinturon et se préparer pour aller sur le terrain. Il était en uniforme.
- J'ai entendu « Criss » et çà venait de la salle d'armes. J'ai entendu « Son gun » de
- Je suis parti pour la salle. J'ai ouvert la porte. Je suis le premier à être entrée. J'ai vu qui pointait son arme devant lui à 45° vers le bas. Il tenait son arme d'une main. Il semblait ne plus savoir quoi faire.
- J'ai remarqué une douille vide à terre et la poussière dans l'air.
- J'ai demandé à de décharger son arme. Il a enlevé le chargeur et il m'a donné le pistolet. Je suis allé au puits de déchargement et j'ai actionné la glissière pour éjecter la balle dans le canon.
- J'ai repris le chargeur de et l'ai inséré dans le pistolet. J'ai actionné la glissière. J'ai ensuite déchargé l'arme de nouveau. J'ai remis l'arme à et il l'a remis dans son casier. m'a dit qu'il avait eu de la difficulté avec l'arrêtoir de la glissière. Il a dit souvent : « J'ai eu de la misère à remettre la pinne... ». J'ai récupéré le plomb dans le fond de l'armoire et la douille par terre.
- Je me suis alors occupé de s'en allait au Palais de justice de Percé. Je lui ai remis mon arme de service parce qu'il avait déjà son ceinturon. Je suis allé au Palais de justice avec lui.

Sous-question des enquêteurs concernant les aptitudes de l'agent dans le maniement général de son arme de service :

-
-
- En fin d'avant-midi, j'ai récupéré l'arme de service sur demande de Marc Naud, préposé régional aux armes à feu.
- Quand l'incident est arrivé, j'ai avisé Vincent Malouin (Directeur de secteur Gaspésie & Bas Saint-Laurent) en premier lieu, ensuite Marc Naud, préposé régional aux armes à feu et finalement Andrew Rowsell (Chef C&P, Secteur Gaspésie & Bas Saint-Laurent) et Éric Mauger (Superviseur C&P, Détachement Gaspé Nord).

Fin de l'entrevue à 08h53.

Deuxième témoin

est agent des pêches dans le Secteur Gaspésie & Bas Saint-Laurent, Détachement Gaspé Nord

Début de l'entrevue – 09h00.

Les enquêteurs demandent à l'agent de décrire en détail et au meilleur de sa mémoire les circonstances de l'incident de tir survenu le 26 mars vers 08h10 au bureau de Gaspé.

Agent

- Ce matin-là, j'étais assis à mon bureau et j'étais au téléphone. J'ai entendu un bruit. J'ai pensé que c'était une porte qui claquait mais l'agent a dit : « C'est une arme à feu ». Je savais que était en uniforme et se préparait pour aller au Palais de justice.
- La porte de la salle des armes était fermée. est entré le premier suivi de moi le troisième. J'ai vu qui tenait son arme à feu dans sa main. Il y avait de la poussière dans l'air, un «Fiumme».
- J'ai vu une douille parterre. Il avait son arme dans les mains et il disait : « c'est la pinne, c'est la pinne». Je ne comprenais pas pourquoi il disait çà.
- J'ai vu l'agent prendre l'arme et enlever la douille dans la chambre. J'ai vu enlever une balle de la chambre mais je ne sais pas si le chargeur était enlevé. Il y avait une douille par terre. Je peux pas en dire plus mais a pris l'arme de et a mentionné qu'il allait l'envoyer à l'armurier.
- J'ai vu ensuite armé de nouveau parce qu'il allait au Palais de justice.
- Je ne comprends pas que l'arme n'aurait pas fonctionné parce qu'il y avait une autre balle dans la chambre après le coup de feu. Alors, je suppose que le chargeur était en place.

[redacted]

Sous-question des enquêteurs concernant les aptitudes de l'agent [redacted] dans le maniement général de son arme de service :

[redacted]

Sous-question des enquêteurs sur l'utilisation du puits de déchargement :

- Le puits de déchargement est utilisé pour le déchargement mais pas pour le chargement. C'est un comportement général. C'est un puits de « déchargement ». Tout de suite après l'incident on a reçu une note pour nous aviser d'utiliser le puits pour le chargement et le déchargement.

Fin de l'entrevue – 09h23.

Troisième témoin [redacted]

[redacted] est agent des pêches dans le Secteur Gaspésie & Bas Saint-Laurent, Détachement Gaspé Nord [redacted].

Début de l'entrevue – 09h28.

Les enquêteurs demandent à l'agent [redacted] de décrire en détail et au meilleur de sa mémoire les circonstances de l'incident de tir survenu le 26 mars vers 08h10 au bureau de Gaspé.

- Je ne me rappelle pas de l'heure exactement, entre 08h00 et 08h15 possiblement. J'étais debout dans le corridor. Je parlais avec [redacted]
- On a entendu un « bang ». J'ai regardé vers la salle d'arme. [redacted] dit : « Il ya une boîte qui a tombé ». J'ai dis que ce n'était pas çà mais une décharge d'arme à feu. Je me suis dirigé vers la salle des armes en suivant [redacted]
- J'ai essayé d'ouvrir la porte mais elle était barrée. J'ai dit : [redacted]
- [redacted] a ouvert la porte. J'ai vu [redacted] debout avec son arme dans la main, pointant vers le bas. Il y avait beaucoup de fumée, de résidus dans la salle.
- J'ai demandé [redacted] s'il était blessé et il m'a dit que non. Je lui ai demandé ce qui était arrivé et il m'a répondu : «C'est la pinne, la pinne» en indiquant son arme. Je ne comprenais pas.
- [redacted] a demandé [redacted] si son arme était déchargée. Quelqu'un a enlevé le chargeur. J'ai vu ensuite le chargeur sur la tablette. [redacted] a pris l'arme, a actionné

la glissière et une autre balle est sortie. Je me suis dit que le chargeur devait être dans l'arme lorsque le coup est parti parce que l'arme s'est chargé de nouveau.
- J'ai ensuite vu où la balle avait frappé et j'ai demandé [redacted] si des éclats de balle l'avaient frappé. Il m'a répondu que non.
- [redacted] m'a dit qu'il ne savait pas ce qui s'était passé, qu'il avait mis un chargeur et qu'il avait « corké » et que le coup était parti.
- Avec toute la fumée, je me suis retiré de la salle. [redacted] est demeuré avec [redacted] pour régler çà.

Sous-question des enquêteurs concernant les aptitudes de l'agent [redacted] dans le maniement général de son arme de service :

[redacted]

Sous-question des enquêteurs sur l'utilisation du puits de déchargement :

- Le puits de déchargement est installé depuis cet hiver. Personnellement, je ne l'utilise pas pour décharger mais toujours pour charger. C'est plus important quand on charge. Pour décharger, je retire le chargeur, actionne la glissière puis installe « la plug ».

[redacted]

- Nos armes de services sont double action, c'est pratiquement impossible qu'il tire sans appuyer sur la gâchette. C'est un accident mais je ne sais pas ce qui a pu causer çà. Faudrait un défaut majeur.

Fin de l'entrevue – 10h00.

Quatrième témoin [redacted]

[redacted] est agent des pêches dans le Secteur Gaspésie & Bas Saint-Laurent, Détachement Gaspé Nord [redacted] Il est l'agent des pêches impliqué dans l'incident de tir du 26 mars 2008.

Début de l'entrevue – 11h00.

Les enquêteurs demandent à l'agent [redacted] de décrire en détail et au meilleur de sa mémoire les circonstances de l'incident de tir survenu le 26 mars vers 08h10 au bureau de Gaspé.

Agent [redacted]

- J'arrive au bureau vers 07h30. Je dois me rendre au Palais de justice de Percé pour rencontrer un huissier et lui remettre plusieurs sommations. Je vais chercher

mon équipement (uniforme & ceinturon) et je vais dans la salle d'armes pour ouvrir mon casier. Je dois vous dire que « J'en ai sauté un bout ». Je vais vous dire ce que normalement j'aurais fait.

- J'ai pris l'arme dans le coffret de transport, dans ma case. J'ai enlevé le verrou de gâchette et j'ai mis « la pinne » (l'arrêtoir de la glissière). J'avais déjà placé mon chargeur quand je me suis aperçu que la « pinne » n'était pas complètement enfoncée. Alors j'ai continué d'essayer d'enfoncer la pinne. Je pense qu'un doigt de l'autre main doit avoir appuyé sur la détente. Le coup est parti. Je n'ai pas fait d'action complète de charger. Selon moi, j'ai fais quelque chose de pas correct, ce n'est pas l'arme, elle ne tire pas par elle-même. J'ai placé la pinne au début et ensuite le chargeur. Ensuite, je me suis aperçu que la pinne n'était pas correcte.
- Après que soit arrivé, j'ai enlevé le chargeur de l'arme et déchargé l'arme avant de l'entreposer. m'a remis une autre arme à feu pour aller au Palais de justice. En revenant au bureau, j'ai remis mon arme à feu et signé les documents de remise.

Sous-question des enquêteurs à l'agent concernant ses aptitudes dans le maniement général de son arme de service :

Sous-question des enquêteurs sur l'utilisation du puits de déchargement :

- J'ai pris mon arme à feu une fois depuis qu'il y a le puits de déchargement. Ce n'était pas dans la routine de charger dans le puits. C'est un puits de déchargement. En voyage, tu n'as pas de puits.
- Après la requalification, l'arme n'a pas été nettoyée. Elle est démontée une fois par année après les requalifications. Sauf cette année, je ne l'ai pas nettoyé par manque de temps (accusations à déposer, retour de congé du procureur).
- Je n'ai aucun problème pendant les requalifications pour le chargement ou le déchargement.
- Au moment ou l'arme a fait feu, ce dont je me souviens c'est le problème avec la pinne. La pinne n'était toujours pas en place.

Fin de l'entrevue – 11h50

Rapport d'inspection de l'armurier de la GRC :

Les principaux résultats obtenus de l'expertise demandée à l'armurerie de la GRC sont les suivants :

INSPECTION VISUEL INITIAL :
L'arme ne démontre aucun dommage visuel à part l'usure normale (égratignures) et de la saleté dû au tir de munition.

ÉPREUVE INITAL :
1. DÉTENTE: À dix (10) reprises la détente a été mesurée en utilisant un appareil électronique (trigger scan) avec une moyenne de 11.107 lbs, qui se trouve dans les normes de la GRC: 8 à 12 lbs.
2. DOUBLE ACTION: La double action de l'arme a été vérifié à plusieurs reprises avec un chargeur chargé de 15 balles de pratique (dummy rounds) et ne démontrait aucun problème.

ÉPREUVE DE TIR
À votre demande, nous avons effectué plusieurs épreuves de tir sur ce pistolet faisant partie de nos enquêtes standards sur des armes impliquées dans une décharge accidentelle.
1. Est-il possible de faire feu avec cette arme en actionnant uniquement la glissière : NON
2. Est-il possible de faire feu avec cette arme en appuyant sur la détente et en actionnant la glissière simultanément : NON

CONCLUSION
Le pistolet Smith & Wessom modèle 5946 # de série [redacted] a été vérifié, tiré et démontre qu'il est des normes de la GRC et de la manufacture. Ce pistolet aurait seulement pu faire feu avec un chargeur en place et un doigt sur la détente qui tire vers l'arrière.

Le rapport complet d'expertise est annexé au présent rapport.

Les circonstances de l'incident de tir :

Aucun témoin, [redacted] n'était présent dans la salle d'armes au moment de l'incident de tir. L'agent [redacted] a indiqué aux enquêteurs qu'il ne se rappelait pas de tous les détails de l'incident. Les enquêteurs ont dû utiliser les informations complémentaires des témoins et du rapport d'expertise de l'armurier pour reconstituer l'incident de tir selon le déroulement le plus probable.

Extraits des témoignages des agents des pêches présents lors de l'incident :

Agent [redacted]	« …J'ai pris l'arme dans le coffret de transport, dans ma case. J'ai enlevé le verrou de gâchette et j'ai mis « la pinne » (l'arrêtoir de la glissière). **J'avais déjà placé mon chargeur quand je me suis aperçu que la « pinne » n'était pas complètement enfoncée. Alors j'ai continué d'essayer d'enfoncer la pinne.** Je pense qu'un doigt de l'autre main doit avoir appuyé sur la détente. Le coup est parti. **Je n'ai pas fait d'action complète de charger**… [redacted] « …Après la requalification, l'arme n'a pas été nettoyée. Elle est démontée une fois par année après les requalifications. Sauf cette année, **je ne l'ai pas nettoyé par manque de temps** (accusations à déposer, retour de congé du procureur). [redacted]
Agent [redacted]	« …Je suis parti pour la salle. J'ai ouvert la porte. Je suis le premier à être entré. **J'ai vu [redacted] qui pointait son arme devant lui à 45° vers le bas.** Il tenait son arme d'une main. Il semblait ne plus savoir quoi faire… » « …J'ai demandé [redacted] de décharger son arme. **Il a enlevé le chargeur et il m'a donné le pistolet. Je suis allé au puits de déchargement et j'ai actionné la glissière pour éjecter la balle dans le canon**… » [redacted]
Agent [redacted]	« …**Il avait son arme dans les mains et il disait : « c'est la pinne, c'est la pinne». Je ne comprenais pas pourquoi il disait çà**… » [redacted]

Agent [redacted]	« ...J'ai demandé [redacted] s'il était blessé et il m'a dit que non. **Je lui ai demandé ce qui était arrivé et il m'a répondu : «C'est la pinne, la pinne» en indiquant son arme.** Je ne comprenais pas... » [redacted]
Rapport d'inspection de l'arme de service S&W 5946 – 9mm. Numéro de série [redacted]	Conclusion : Le pistolet S&W 5946 # de série [redacted] a été vérifié et testé en tir réel. Il démontre qu'il rencontre les normes de la GRC et du manufacturier. **Ce pistolet aurait seulement pu tirer avec un chargeur en place et un doigt tirant la détente vers l'arrière.**

De ces extraits, les enquêteurs peuvent établir quelques constats et énoncer quelques hypothèses de travail (soulignées) :

[redacted]

- Lorsqu'il prend son arme pour la charger, elle n'est pas fonctionnelle. Il remet avec difficulté l'arrêtoir de la glissière en place. Il est plausible que la concentration de l'agent [redacted] ait pu être accaparée par ce point (L'arrêtoir de la glissière n'est pas en place). La routine du chargement de l'arme de service a pu s'en être trouvée perturbée.
- L'agent [redacted] continu la procédure de chargement de l'arme. Il introduit le chargeur mais ne se rappelle pas avoir actionné la glissière. Il tente toujours de pousser l'arrêtoir à sa place. Il est plausible que, son attention étant portée sur l'arrêtoir de la glissière, il ait machinalement actionné la glissière. Il a également pu actionner la glissière suffisamment pour introduire une balle en tentant de replacer l'arrêtoir.
- L'agent [redacted] exerce de sa main gauche une pression sur l'arrêtoir en maintenant fermement son arme de la main droite. À ce moment, il a probablement un doigt sur la détente. La pression de la main gauche a pu engendrer un mouvement sympathique de la main droite. L'agent [redacted] a donc pu appuyer sur la gâchette sans s'en rendre compte.
- Durant toute sa manœuvre, l'agent [redacted] contrôle la direction du canon. Il pointe vers le bas en direction de l'endroit ou se trouvait le bac de sable avant l'installation du puits de déchargement. La balle frappe la porte du dernier cabinet de l'armoire en bas, à gauche, ricoche sur le cadre latéral gauche de l'armoire et termine sa course au fond de l'armoire.
- L'agent [redacted] pointe toujours son arme dans une direction sécuritaire lorsqu'il ouvre la porte de la salle pour laisser entrer les agents [redacted]

Conclusion des enquêteurs

Réponses aux allégations :

Le mandat transmis à l'équipe d'enquête énonce clairement cinq allégations de manquement à la politique sur les armes à feu du MPO et une allégation de manquement à la directive de chargement & déchargement de l'arme de service. Par soucis d'efficacité, les enquêteurs ont choisis de regrouper deux des allégations de manquements à la politique sur les armes à feu. L'analyse des informations obtenues permet aux enquêteurs de répondre aux allégations :

Allégation no 1 : ***L'agent [redacted] aurait déchargé une arme à feu de manière illégale, dangereuse, irresponsable ou non professionnelle contrevenant ainsi à l'article 9 (1) f) de la Politique.***

Cette allégation est non-fondée. L'esprit de cet article de la politique suppose une intention coupable ou répréhensible. Les informations obtenues et les circonstances amènent les enquêteurs à conclure que la décharge de l'arme à feu est accidentelle.

Allégation no 2 : ***L'agent [redacted] n'aurait pas traité l'arme à feu comme si elle était chargée et aurait placé le doigt sur la détente alors qu'il ne s'apprêtait pas à tirer contrevenant ainsi aux articles 32 (1) a) & 32 (1) c) de la Politique.***

Cette allégation est fondée. L'agent [redacted] n'a pas traitée son arme de service comme si elle était chargée et a placé un doigt sur la détente. Toutefois, les circonstances de l'incident démontrent l'absence d'intention coupable ou répréhensible.

Allégation no 3 : ***L'agent [redacted] aurait contrevenu aux dispositions de la Politique (article 35 (B)).***

Cette allégation est non-fondée. Cet article de la politique suppose un geste délibéré, contraire à l'esprit de la Politique, alors que la conclusion des enquêteurs est que la décharge de l'arme à feu est accidentelle.

Allégation no 4 : ***L'agent [redacted] aurait déchargé une arme à feu du Ministère sans se conformer aux dispositions de la Politique (article 69.1 (1)).***

Cette allégation est non-fondée. Cet article de la politique vise la décharge délibérée d'une arme à feu dans des conditions autres que celles permises dans la politique. La décharge accidentelle de l'arme à feu ne correspond pas à cet article.

Allégation no 5 : ***L'agent [redacted] n'aurait pas tenu le doigt éloigné de la détente et hors du pontet contrevenant ainsi aux sections 1 & 2 du document « Pistolet de service – Directives de chargement et de déchargement ».***

Cette allégation est non-fondée. Les sections 1 & 2 du document ***« Pistolet de service – Directives de chargement et de déchargement »*** désigne et préconise le chargement de l'arme à l'étui. Cette pratique, non-recommandée par les instructeurs de la GRC, n'est pas enseignée par les instructeurs du MPO, Région du Québec depuis au moins deux ans. En raison de cette ambiguïté, il n'est pas souhaitable d'utiliser cette directive pour évaluer l'incident de tir sous enquête.

Conclusion :

Les enquêteurs sont d'avis que l'incident de tir survenu au bureau de secteur du MPO à Gaspé le 26 mars 2008 dans les locaux de C&P est accidentel et ne résulte pas d'une intention répréhensible (geste illégal, dangereux, irresponsable ou non-professionnel). Il s'agit plutôt d'une série de manquements mineurs à la politique favorisant la mise en place des conditions nécessaires pour qu'un maniement inadéquat produise cet incident de tir.

Le respect des procédures d'entretien, d'entreposage et de maniement des armes à feu prévu dans ***Politique et procédures sur les armes à feu du MPO*** aurait permis d'éviter cet incident. Notamment les articles suivants :

Article 32 (1) Toute personne qui manipule une arme à feu :

a) doit traiter l'arme à feu comme si elle était chargée,

b) doit ouvrir le mécanisme et vérifier que l'arme à feu est désapprovisionnée chaque fois qu'il la manipule, exceptée lorsqu'elle est dans son étui, lorsqu'il tire ou qu'il prépare autrement l'arme pour effectuer des opérations liées à ses fonctions.

Puisqu'il n'était pas satisfait de la mise en place de l'arrêtoir de la glissière, l'agent [redacted] s'est vu dans l'obligation de manipuler son arme de service beaucoup plus que l'exige un simple chargement de l'arme. Dans ce cas, il aurait dû retirer le chargeur, bloquer la glissière à l'arrière et vérifier si son arme était vide avant toute manipulation.

Article 45 (1) Un agent des pêches qui a reçu une arme à feu approuvée s'assure, avant de l'entreposer, qu'elle est :
a) propre.
b) …

(2) Lorsque l'agent des pêches qui a reçu une arme à feu approuvée l'entrepose, il :
a)…
b) la vérifie tous les mois pour y déceler toute trace de rouille ou de corrosion.

Au retour de sa requalification annuelle, l'agent [redacted] se devait de nettoyer son arme de service avant de l'entreposer. Si cet article avait été respecté, l'arme de l'agent [redacted] aurait été remontée et prête pour le service le 26 mars 2008. La manipulation

supplémentaire pour la mise en place de l'arrêtoir de la glissière et l'incident de tir lui-même aurait été évitée.

[redacted]

Recommandations :

Les enquêteurs recommandent que :

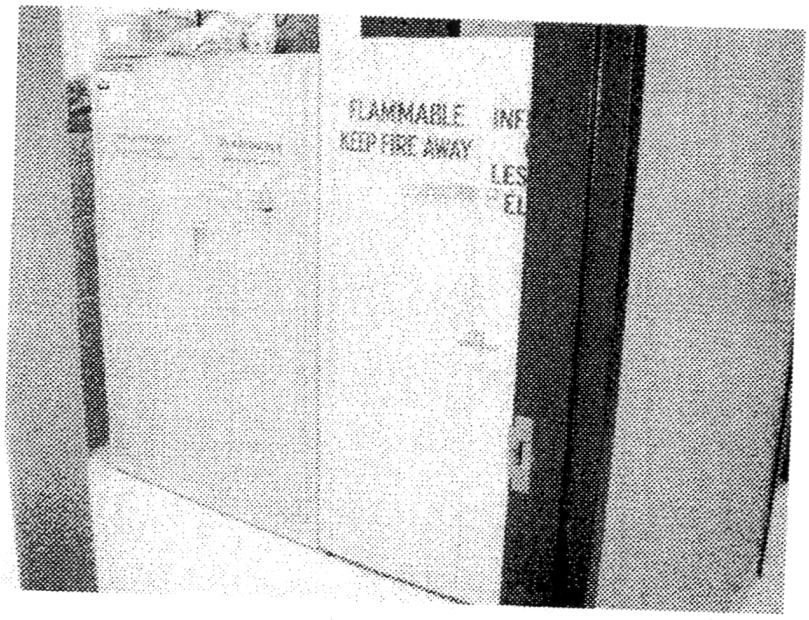
[redacted]

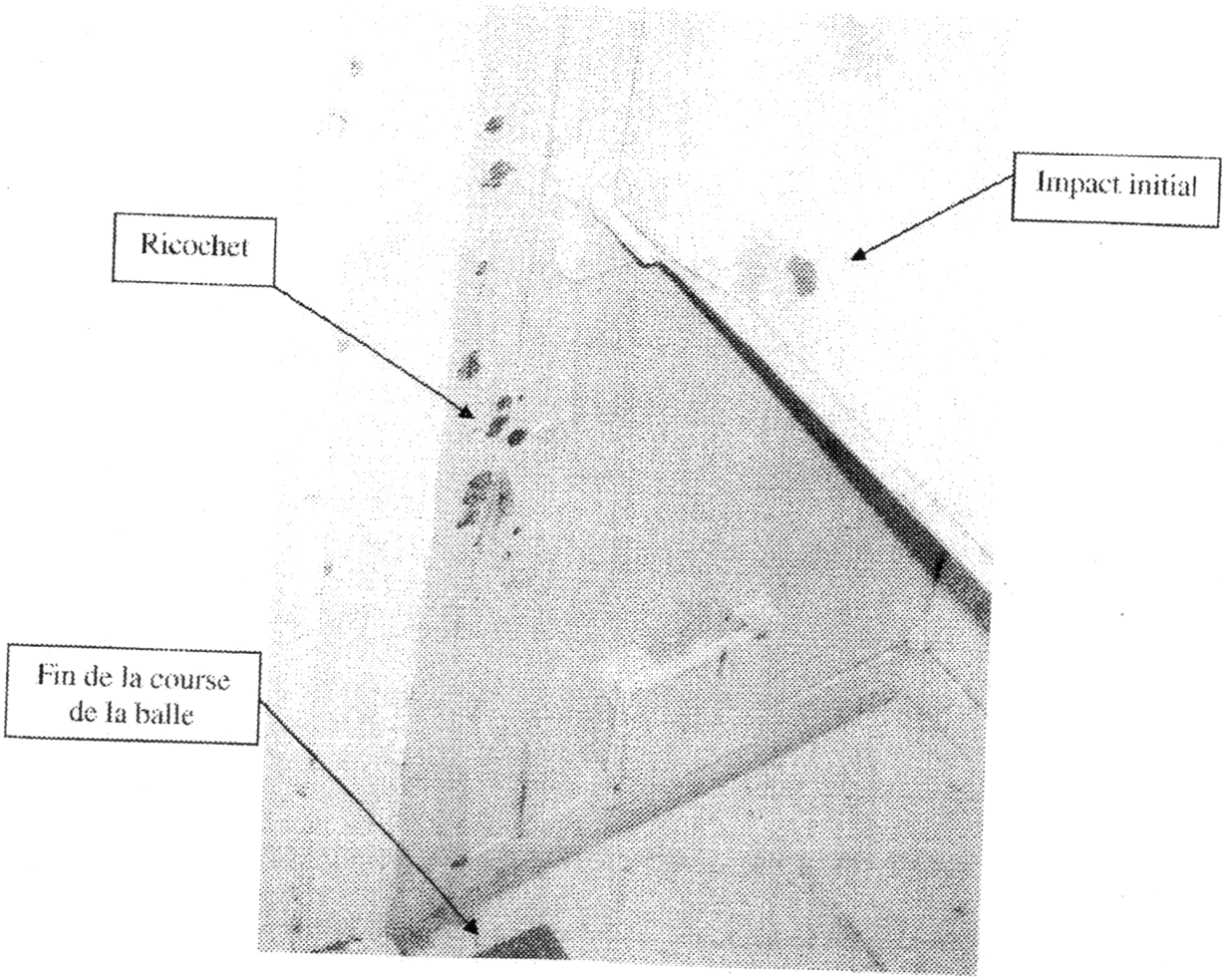
Les enquêteurs recommandent que la Direction C&P renforce l'importance, pour tous les agents des pêches, de l'entretien de leur arme de service, conformément à la politique et dans les meilleurs délais lors de retour au bureau.

Finalement, les enquêteurs recommandent que la Direction C&P incite (par une affiche ou lors des requalifications) les agents des pêches à utiliser le puits de déchargement pour le chargement et le déchargement de l'arme de service lorsque cet équipement est disponible.

Les enquêteurs tiennent à souligner la bonne collaboration de tous les agents des pêches ayant participés à cette enquête.

Annexe 1 : Photos des lieux de l'incident





Annexe 2

Rapport d'inspection d'arme de service
Smith & Wesson 9 mm, model 5946
Numéro de série [redacted]

(Voir fichier PDF annexé)

RAPPORT D'INSPECTION D'ARME DE SERVICE
SMITH & WESSON 5946 9MM
NUMÉRO DE SÉRIE [redacted]

INSPECTION VISUEL INITIAL: L'arme ne démontre aucun dommage visuel a part l'usure normale (égratignures) et de la saleté du au tire de munition.

EPREUVES INITIAL:

1. DÉTENTE: A 10 reprises la détente a été mesurée en utilisant un appareil électronique (trigger scan) avec une moyenne de 11.107 lbs, qui se trouve dans les normes de la GRC; 8 a 12 lbs .

2. DOUBLE ACTION: la double action de l'arme a été vérifiée a plusieur reprise avec un chargeur chargé de 15 balles de pratique (dummy rounds) et ne démontrait aucun problème.

3. SÉPARATEUR (disconnector): Plusieurs épreuves on été effectuée pour vérifier le fonctionnement du séparateur et aucun problème n'a été démontré.

4. BIELLE D'ARRÊTOIR DE CHARGEUR: Le pistolet n'avait aucun problème avec l'arrêtoir de chargeur.

5. MOUVEMENT DE LA GLISSIÈRE: Le mouvement de la glissière était libre, lisse, avec aucune interférence.

6. ARRÊTOIR (slide stop): Une inspection visuelle et mécanique a été effectuée sur cette pièce et aucun défaut apparent a été décelé.

7. MOUVEMENT DU CANON: Le mouvement et le verrouillage du canon répond aux normes de la GRC.

8.CHARGEURS: Les trois chargeurs qui accompagnait le pistolet on été inspecté et démontre aucun défaut.

9.EXTRACTEUR: La tension de l'extracteur était de 8.5 lbs qui répond aux normes de la manufacture et les épreuves de gauge (GO / NO GO) on été administrer avec succès.

10.MIRES: Les mires démontrent une très bonne luminosité.

DÉMONTAGE SOMMAIRE (field stripping):

1.BIELLE DU LEVIER DE SÛRETÉ DU PERCUTEUR: Aucun dommage perçu, mouvement libre et lisse avec aucune interférence.

2.BIELLE D'EJECTEUR: Usure normale perçu mais encore bien en mesure de ces fonction, aucun problème pertinent.

3.EJECTEUR ET SÉCURITÉ DE CHARGEUR: Usure normale perçu, mais encore fonctionnel, aucun problème pertinent.

4.PERCUTEUR: Percuteur propre et en bonne états.

5.TROU DU PERCUTEUR: Le trou du percuteur était propre et sans obstruction.

6.RESSORT DE PERCUTEUR: Le ressort était droit, avait une bonne tension et il était fonctionnel.

EPREUVE DE TIR:

A votre demande nous avons effectuée plusieurs épreuves de tir sur ce pistolet qui font parti de nos enquête standard sur des armes impliquée dans une décharge accidentel.

1.Est-il possible de faire feu avec cette arme en actionnant uniquement la glissière: - NON-

2.Est-il possible de faire feu avec cette arme en appuyant sur la détente et en actionnant la glissière simultanément:-NON-

Nous avons tirés un total de 45 balles 9mm luger 147gr. (30-Winchester Ranger SXT et 15-Winchester Ranger full metal jacket) en utilisant les trois chargeur fournis avec le pistolet a une distance de 7m sur une cible standard de la GRC. Le pistolet démontre un chargement, une alimentation, un tir et une éjection sans aucun problème. Le pistolet démontre une très bonne précision de tir.

DÉSASSEMBLAGE DU PISTOLET: Voir document intituler "DISASSEMBLY" pour un rapport sur chaque pièces.

s.19(1)

DISASSEMBLEY

GUN TYPE: smith & wesson 9mm
MODEL: 5946
SERIAL NO. [redacted]

	RCMP/FACTORY SPECIFICATIONS POOR/FAIR/EXCELLENT	DIRTY	WORN	BROKEN	SERVICEABLE OR REPLACE	COMMENT
MAGAZINE						
FRAME	excellent	x			serviceable	
SPRING	fair		x		replace	should be replaced but still functional
FOLLOWER	fair	x	x		serviceable	normal wear
BUTT PLATE	fair		x		serviceable	normal wear
SLIDE						
RECOIL SPRING	excellent	x			serviceable	
RECOIL GUIDE ROD	excellent	x			serviceable	
BARREL	fair	x	x		serviceable	normal wear, scratches on crown
EXTRACT-OR	excellent	x			serviceable	
FIRING PIN RETAINER	excellent	x			serviceable	
FIRING PIN	excellent	x			serviceable	
FIRING PIN SPRING	fair				serviceable	normal wear

FRONT SITE	excellent				serviceable	
REAR SITE	excellent				serviceable	
EJECTOR DEPPRES-OR PLUNGER	fair		x		serviceable	normal wear
FIRING PIN SAFETY PLUNGER	excellent				serviceable	
SLIDE STOP	excellent	x			serviceable	
SPRINGS	fair				serviceable	normal wear
FRAME						
GRIP	fair				serviceable	normal wear
MAIN-SPRING / PLUNGER	excellent				serviceable	
SIDEPLATE	excellent				serviceable	
HAMMER	excellent	x			serviceable	
EJECTOR	fair	x	x		serviceable	normal wear
SAFETY LEVER	excellent	x			serviceable	
SEAR / SEAR SPRING	excellent	x			serviceable	
DISS-CONNECT-OR	excellent	x			serviceable	

TRIGGER	excellent	x			serviceable	
DRAWBAR	excellent	x			serviceable	
DRAWBAR PLUNGER	excellent	x			serviceable	
OTHER extracter pin hole	poor		x		replace	slide must be replaced

NOTES: La goupille d'extracteur (#17 dans le schéma attaché) est la pièce qui retient l'extracteur en place dans la glissière. Le trou dans la glissière ou on insert la goupille montre des signes d'agrandissement qui pourrait développer un problème d'extraction au future. Cette pièce est sensée offrir une résistance en la retirant, mais dans ce cas ci, il y en avait moins que désirer. Ce problème ne peut pas être rectifié, donc comme précaution la glissière doit être remplacé. Ce problème est de l'usure normale qui est attribué par le nombre de service que ce pistolet aurait eu au long de ca carrière. Ceci est seulement une précaution et n'a aucunement contribuer a une décharge accidentel. Nous allons donc retenir ce pistolet et vous fournir avec un remplacement parce que nous n'avons pas de glissière pour la remplacer en inventaire.

CONCLUSION: Le pistolet Smith & Wesson model 5946 # de série [redacted] a été vérifier, tirer et démontre qu'il est dans les normes de la GRC et de la manufacture. Ce pistolet aurait seulement pu tirer avec un chargeur chargé et un doigt sur la détente qui tire vers l'arrière.

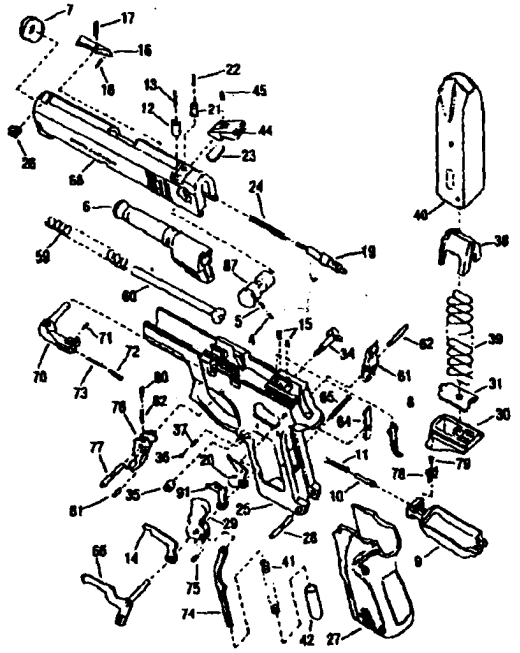
Inspection complétée par:

Marc Aspinall
Armurier
1426 St-Joseph blvd, bldg.408
Ottawa, Ontario
K1A 0R2
Tel:613-993-3100
Fax:613-993-5533

Marc Aspinall
Armourer signature

10 AVRIL 2008
Date

LE PISTOLET SEMI-AUTOMATIQUE À DOUBLE ACTION SEULEMENT SMITH & WESSON



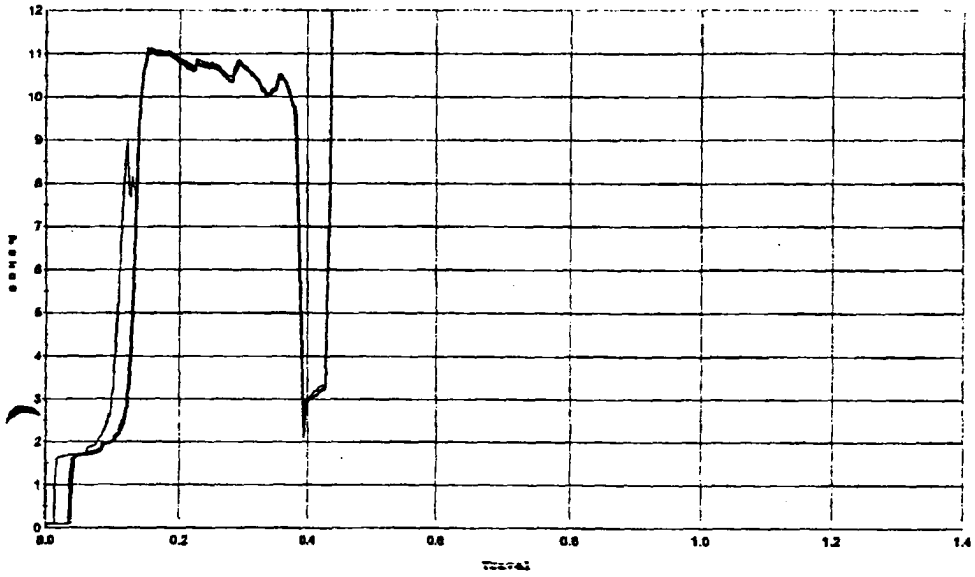
PISTOLETS SEMI-AUTOMATIQUES À DOUBLE ACTION SEULEMENT - LISTE DES PIÈCES

Nº DE PIÈCE	DESCRIPTION
04	Bielle du RP
05	Ressort de la bielle du RP
06	Canon
07	Manchon de canon
08	Séparateur
09	Étrier d'armement
10	Bielle d'étrier d'armement
11	Ressort de bielle d'étrier d'armement
12	Bielle d'éjecteur
13	Ressort de bielle d'éjecteur
14	Éjecteur et sécurité de chargeur
15	Ressort d'éjecteur
16	Extracteur
17	Goupille d'extracteur
18	Ressort d'extracteur
19	Percuteur
20	Levier de sûreté de percuteur
21	Bielle de levier de sûreté du percuteur
22	Ressort du levier de sûreté du percuteur
23	Cale du ressort du levier de sûreté du percuteur
24	Ressort de percuteur
25	Carcasse
26	Guidon
27	Crosse
28	Goupille de plaquette de crosse
29	Chien
30	Plaque de fond du chargeur
31	Plaque de fixation
34	Arrêtoir de chargeur
35	Écrou d'arrêtoir de chargeur
36	Bielle d'arrêtoir de chargeur
37	Ressort d'arrêtoir de chargeur
38	Plateau de chargeur
39	Ressort de chargeur
40	Corps de chargeur
41	Ressort de percussion
42	Guide du ressort du chien
44	Hausse
45	Vis de réglage
59	Ressort de rappel
60	Sous-tige du ressort de rappel
61	Gâchette
62	Axe de gâchette
63	Levier de détente
64	Ressort de gâchette
65	Goupille du ressort de gâchette
66	Plaque de visée
68	Glissière
70	Arrêtoir
71	Goupille d'arrêtoir
72	Bielle d'arrêtoir
73	Ressort de la bielle d'arrêtoir
74	Queue de chien
75	Goupille
76	Groupe de détente
77	Goupille de détente
78	Ressort de jeu de détente
79	Rivet du ressort de jeu de détente
80	Bielle de détente
81	Goupille de la bielle de détente
82	Ressort de la bielle de détente
87	Arrêtoir du percuteur
91	Levier d'espacement de l'arrêtoir du percuteur

Cet éclaté des pièces correspond aux normes actuelles. Il se peut que des modifications soient apportées et que votre arme ne corresponde plus aux renseignements donnés sur cette page.

TriggerProfile [lbs,inch]

Profile	Profile2	**Model:**	5946
GunType:	semi-auto 9mm	**Serial No:**	VDH0519
Make:	smith&wesson	**Trigger:**	double action
Note:			



	Peak Force	Travel To Actuate	Initial Take-up	Overtravel	Energy To Actuate	Lock Time	Action Type
1	11.121	0.382	0.014	0.051	0.000		Double Action
2	11.099	0.380	0.036	0.062	2.789		Double Action
3	11.131	0.382	0.037	0.063	2.800		Double Action
4	11.119	0.380	0.039	0.053	2.781		Double Action
5	11.117	0.380	0.037	0.063	2.783		Double Action
6	11.118	0.383	0.037	0.063	2.800		Double Action
7	11.113	0.380	0.037	0.063	2.780		Double Action
8	11.096	0.380	0.038	0.063	2.772		Double Action
9	11.074	0.381	0.037	0.062	2.788		Double Action
10	11.081	0.382	0.039	0.063	2.782		Double Action

Trigger Scan 2.01 ,SN 012450, printed by RCMP Armourer section 2/23/2000 5:48:58 PM

Profile2

ke:	Model:	Test Nr.	Force	Travel	Take-up	Overtravel	Energy	Lock Time
smith&wesson	5946		[lbs]	[inch]	[inch]	[inch]	[lbs.inch]	[ms]
Double Action		1	11.121	0.382	0.014	0.061	0.000	
		2	11.099	0.380	0.036	0.062	2.789	
		3	11.131	0.382	0.037	0.063	2.800	
		4	11.119	0.380	0.039	0.063	2.781	
		5	11.117	0.380	0.037	0.063	2.783	
		6	11.118	0.383	0.037	0.063	2.800	
		7	11.113	0.380	0.037	0.063	2.780	
		8	11.096	0.380	0.038	0.063	2.772	
		9	11.074	0.381	0.037	0.062	2.768	
		10	11.081	0.382	0.039	0.063	2.782	
		Avg:	11.107	0.381	0.035	0.063	2.508	0.00 ms

TOTAL AVG

Double Action			11.107	0.381	0.035	0.063	2.508	0.00 ms

Pages 65 to / à 66

are withheld pursuant to section

sont retenues en vertu de l'article

19(1)

of the Access to Information Act

de la Loi sur l'accès à l'information

Fisheries and Oceans Canada | Pêches et Océans Canada

MEMORANDUM NOTE DE SERVICE

s.19(1)

To / À
Marc Demonceaux
Directeur général régional
Conservation et Protection, région du Québec

From / De
Paul Steele
Directeur général
Conservation et Protection

Security Classification - Classification de sécurité
Our File - Notre référence
Your File - Votre référence
Date July 21 2008

Subject / Objet

AGENT DES PÊCHES [redacted] – ENQUÊTE SUR UN INCIDENT IMPLIQUANT UNE ARME À FEU

Conformément à la Politique et aux procédures concernant les armes à feu, le rapport d'enquête de niveau 1 relativement à un incident impliquant l'usage d'une arme à feu par l'agent des pêches [redacted] est terminé.

Un Comité d'examen a donc été mis sur pied afin d'étudier l'incident au cours duquel l'agent [redacted] a déchargé de façon non autorisée une arme à feu du Ministère.

L'agent [redacted] a eu la possibilité d'examiner le rapport d'enquête et de faire ses commentaires.

[redacted]

Le Comité d'examen est arrivé à la conclusion que l'agent [redacted] a enfreint les dispositions suivantes de la Politique et des procédures sur les armes à feu :

l'alinéa 32(1)(a) – il n'a pas traité son arme à feu comme si elle était chargée;

l'alinéa 32(1)(c) – il a placé son doigt sur la détente alors qu'il ne s'apprêtait pas à tirer.

Ottawa, Canada
K1A 0E6

Canada

Des agents des relations de travail du Ministère et un avocat des Services juridiques ont revu le dossier et ils sont d'accord avec les recommandations du Comité d'examen.

Vu la nature de cet incident et les conséquences pour le Ministère, il est justifié que les mesures correctrices et disciplinaires ci-dessous soient prises :

[redacted]

La présente met un terme au volet enquête de cet incident impliquant l'usage d'une arme à feu.

Je vous serais reconnaissant de transmettre à mon bureau copie de tout document relativement à quelque autre mesure qui pourrait être prise par vous-même ou d'autres fonctionnaires du bureau régional relativement à cette affaire.

Paul Steele

Cc. John Chouinard
Sarah Tessier
Renée Roy

Page 69

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de la Loi sur l'accès à l'information

s.19(1)

Firearms Incident Investigation
January 18-19, 2011
Slemon Park, PEI

Investigators: Donald Rodd (APA Senior Firearms Instructor)
Charles Cormier (DFO Firearms Instructor)

The purpose of the investigation was to determine the cause of the unintentional discharge of a firearm during a qualification exercise on December 22, 2010 at the Atlantic Police Academy at Slemon Park, PEI. The investigation was meant to determine if Officers [redacted] failed to handle a firearm in a safe manner, as prescribed in the Firearms Policy and Procedures.

Background: Officer [redacted] had a pistol in the lock back position in his hand coming out of a cubicle at the Atlantic Police Academy firing range on December 22nd, 2010 and a shot went off.

Summary of Findings: The first element that was examined was the video footage from the firing range at the Atlantic Police Academy in Prince Edward Island. The investigators looked at the video from the time officer [redacted] took the firearm from Fishery Officer [redacted] until the firearm discharged. The firearm was in the lock back position the whole time. After the round discharged, Officer [redacted] then racked the firearm.

I then interviewed each officer that was involved in the December 22nd, 2010 incident namely fishery officer [redacted] who was doing a requalification with the sidearm involved in the incident, firearm instructors Dave Austin and Craig MacDonald.
After my interviews here are our observations:

1. The firearm in question had been malfunctioning and jamming all morning.

2. The round that discharged from the firearm is what is known as a slow cooker[1].
3. No finger was on the trigger when the round discharged.
4. The firearm was in a lock back position when the round discharged.

There are some inconsistencies from the evidence of the witnesses in terms of what transpired. They are:

- Officer [redacted] said he looked in the barrel twice before handing his pistol to Officer [redacted] but didn't see a shell.
- Officer Austin said he was in the cubicle when the shot went off and in the video he was in another room (range control room).
- Officer [redacted] said that the round discharged when he cycled the action, when, in the video, it is clear the round discharged before he cycled the action.

The investigators noted that Officer [redacted] didn't have a finger on the trigger when the round discharged and that the action was in the lock back position. There were nevertheless errors committed that led to the round discharging behind the firing line (in the alley behind the cubicles).

First officer [redacted] said he checked the barrel twice and didn't see a round which is possible but unlikely as there was a round in the chamber.

Second officer [redacted] didn't look or poke in the chamber when taking possession of the pistol. He assumed the pistol was empty after seeing Officer [redacted] cycle the action a number of times and looking in the chamber to check that it was empty.

[1] Conclusion was reached with the assistance of Mr. Donald Rodd, a senior firearms instructor and ballistics specialist.

We are satisfied that the round was going to detonate no matter what the officers did. In this case, because of human error, the round discharged in a dangerous place.

The fact that the pistol was in lock back position prevented the bullet from being propelled with a lot of velocity and in turn probably helped in not having far worse consequences than just slightly damaging the cement floor.

Were there any breaches to the firearm policy by Officers [redacted]?

The investigators were to examine all the evidence and speak to witnesses in order to determine whether there had been any breaches of the Firearms Policy and Procedures. In our view, there were two sections of the policy that are at issue.

Section 32 (1) (b) of the policy states:
Every person who handles a firearm shall point the muzzle of a firearm in a safe direction at all times, unless deliberately engaging a target.

An officer is supposed to point the muzzle in a safe direction at all times. [redacted] When the round discharged, it went in a 30 degree angle to the left and into the cement floor.

Conclusion:
That officer [redacted] did not point the firearm in the safest possible direction.

Section 32 (1)(d) of the policy states:
Every person who handles a firearm shall open the action and verify that the firearm is unloaded every time the firearm is handled except when holstering, drawing or otherwise preparing the firearm in order to carry out operational duties.

In this instance after looking at the video, getting testimony from the officers involved we conclude that both officers failed to verify that the firearm was unloaded. Officer [redacted] says he looked to see if the pistol was unloaded and Officer [redacted] took the pistol from Officer [redacted] assuming it was unloaded. Therefore both officers didn't assure themselves that the firearm was actually unloaded and empty.

Conclusion:
That officers [redacted] both failed to ensure that the firearm was unloaded.

Pawloski, Tom

From: [redacted]
Sent: Monday, June 6, 2011 3:53 PM
To: Elson, Richard; Higgins, Linda; [redacted] Pawloski, Tom; Koshowski, Denise; [redacted]
Subject: Unintentional discharge of 9mm Smith & Wesson sidearm while using covert holster, May 30, 2011

Afternoon Richard, with regards to the above subject matter please refer to the attachment below. If you have any question please do not hesitate to call me. Thank you.

Unintentional discharge of 9m...

[redacted]

Unintentional discharge of 9mm Smith & Wesson sidearm using covert holster

On Monday, May 30, 2011, Officer [redacted] attended the D.F.O. Rural Surveillance Tactics (RST) training course held at Shelton Lake, near Nanaimo, B.C. At approximately 1055 hours, Officer [redacted] removed his sidearm from the metal sidearm box in his vehicle. Officer [redacted] then pointed his sidearm in a safe direction and inserted his duty magazine into the pistol then "tap, racked and holstered" his side arm into his new Safariland, Model 518, for the S&W 5946 – officer [redacted] duty sidearm, at no time was Officer [redacted] finger on the trigger. Upon holstering the sidearm officer [redacted] heard his side arm discharge, immediately he looked around to see if anyone was injured. Officer [redacted] who was off to officer [redacted] right side indicated he was okay. Officer [redacted] then asked the officers in the area, approximately forty feet if they were okay which was confirmed. Fortunately there were no injuries. Officer [redacted] noticed a patch of disturbed ground (appeared to be where the spent round had entered the ground) approximately a foot and half behind his right heel. Officer [redacted] immediately checked his sidearm in a safe direction, removed the magazine and ejected a live round out of the chamber. The side arm, with the breech open, was placed back in to the trucks side metal box where it was secured. This round was placed back into the magazine. Shortly after Officer [redacted] proceeded down a dirt road towards Shelton Lake where at approximately 1058 hours, he met with Fishery Officers [redacted] Denise Koshowski [redacted] Officer [redacted] informed the officers that his sidearm had discharged and that no one was injured. Officer [redacted] advised that while holstering his sidearm the thumb break strap had entered the trigger guard, thus depressed the trigger. Officer [redacted] indicated that he had not used a covert holster – other than the normal duty holster for a number of years. Note: This covert holster was acquired at the Nanaimo C&P office, during this time the Nanaimo C&P Detachment Supervisor was Bryan Jubinville, prior to this he was the I&I Detachment Supervisor. Officer [redacted] accompanied [redacted] back up the hill to his fisheries truck, where officer [redacted] reenacted the event. Shortly after Officer [redacted] extracted a round from the disturbed piece of ground as well as picked up a spent shell casing nearby which he kept in his possession. Shorty after Officer [redacted] met with Denise Koshowski, who is a Firearms Instructor, and a safe direction proved his pistol unloaded - to her. The empty sidearm was slowly holstered. It was determined that during the holstering process the thumb break strap had entered the trigger guard thus applying enough to depress the trigger and cause the pistol to fire. Denise Koshowski took several photos of the holster and the trigger guard. This was a new covert holster and was very stiff. After this incident Denise Koshowski had instructed Officer [redacted] as well as the other officers, if any of the officers had the same covert holster to ensure the pistol is holstered slowly and the ensure the thumb break strap is held back. Officer [redacted] continued to use this holster for the remainder of the training course – no further issues arose – but Officer [redacted] took special care when holstering.

Cormie, Mya

From: XNCR, C&P Info
Sent: Tuesday, June 14, 2011 11:39 AM
To: Berthier, Jacinta; Bruinsma, Sid; Jenkins, Randy; Poirier, Gerald - NHQ; Swerdfager, Trevor; XCA-Grp, C&P FO All Staff; XGLF-GRP, All C&P/Fishery Officers; XLAU, Agents-des-pêches; XMAR-GRP, SF-Fishery-Officers; XNFL-Group, All Fishery Officers; XPAC FM C&P FO ONLY
Subject: Enforcement Bulletins // Bulletins d'Application des règlements

Please take note of the two Enforcement Bulletins regarding firearms.


Enforcement Bulletin-Firearm...


Enforcement Bulletin-Firearm...

The documents will be posted at: http://intra.dfo-mpo.gc.ca/hq/fishmgmt/Directorates/CP/policies-politiques/enfbulletins-eng.htm

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Veuillez noter les deux Bulletins d'application des règlements au sujet des armes à feu.


Enforcement Bulletin-Firearm...


Enforcement Bulletin-Firearm...

Les documents seront afficher à: http://intra.dfo-mpo.gc.ca/hq/fishmgmt/Directorates/CP/policies-politiques/enfbulletins-fra.htm

Thanks / Merci,

Jacinta Berthier
Chief, Enforcement Policies and Standards | Chef, Politique et normes d'application des règlements
Conservation and / et Protection
Fisheries and Oceans Canada | Pêches et Océans Canada
200 Kent Street | 200, rue Kent
Ottawa, Ontario K1A 0E6
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Fisheries and Oceans Canada | Pêches et Océans Canada

Enforcement Bulletin - Bulletin d'application des règlements

Firearms-Clearing Stoppages | Armes à feu -- Désenrayer une arme à feu

2011-05-27

Purpose

This Bulletin is published in response to a recent incident during annual firearms re-qualification that warrants the issuance of this bulletin. The incident involved what is believed to have been a delayed detonation of a 9mm ammunition round (sometimes referred to as a hang-fire).

Background

During firearms re-qualification, an officer experienced a number of stoppages with the 9mm duty pistol. As per training directives, the officer attempted to clear the pistol using phase I and II stoppage procedures. The officer was not successful in clearing the round. With the slide in the lock-back position, the 9mm round detonated (hang-fire). Fortunately, no one was injured.

A hang-fire is the delayed detonation of ammunition. It involves the striking of the primer but a failure of the powder to immediately ignite. In most cases, the round will not detonate and is commonly referred to as a "dud". In hang-fires, the round can detonate within a few seconds to a few minutes as the result of slow burning gunpowder. These most often occur with rifle cartridges and are rare in small arms ammunition.

Cause and Action

The 5946 Smith & Wesson pistol has a number of safety features, and is designed to only be fired with a loaded magazine in the pistol and engaging the trigger. While hang-fires are extremely rare, caution must be taken when a fired round does not detonate.

Objet

La publication de ce bulletin provient directement d'un incident récent pendant le cours annuel de renouvellement de la qualification au tir. L'incident met en cause ce qui pourrait être l'explosion différée d'une cartouche de 9 mm (parfois désigné sous le nom de retard d'allumage).

Contexte

Pendant la formation de renouvellement de la qualification au tir, le pistolet de service de 9 mm d'un agent s'est enrayé à plusieurs reprises. Conformément aux directives de la formation, l'agent a tenté de le désenrayer en mettant en pratique les étapes I et II des procédures de déblocage. L'agent n'a pas réussi à extraire la balle. La glissière est demeurée coincée vers l'arrière et quelques instants plus tard, le projectile de 9 mm a explosé (retard d'allumage). Heureusement, personne n'a été blessé.

Un retard d'allumage est un délai dans l'explosion de la munition. Ceci signifie que l'amorce a été percutée, mais que la poudre ne s'enflamme pas immédiatement. Dans la plupart des cas, la cartouche n'explosera pas et sera communément désignée comme un « raté ». En ce qui concerne les retards d'allumage, la poudre peut prendre quelques secondes ou quelques minutes à exploser, en raison de la combustion lente de la poudre. Ce typed'incident se produit généralement avec des cartouches de carabine et plus rarement avec les munitions pour armes légères.

Cause et action

Le pistolet Smith & Wesson 5946 comporte quelques dispositifs de sécurité. Il est conçu pour faire feu seulement lorsque le chargeur est garni et que le tireur a un doigt sur la détente. Même si les retards d'allumage sont extrêmement rares, il faut faire preuve de prudence lorsqu'une balle refuse d'exploser.

Firearms-Clearing Stoppages

While hang-fires are not common, it is important to identify what measures should be taken when stoppages occur. As outlined in firearms training procedures, there are three progressive phases for clearing stoppages which are meant to build response skills for tactical situations, as follows:

- **Phase I** - Tap the magazine aggressively to ensure it is seated; rack slide aggressively, using an overhand grip and release; re-assess and proceed with your goal.
- **Phase II** (If Phase I does not work) - Seek cover or make yourself a smaller target; retrieve/index a new magazine; release the magazine from the firearm, using the new magazine if necessary to assist in stripping the magazine; insert the new magazine; rack the slide aggressively; and, re-assess.
- **Mechanical Malfunction** (When Phase I and II do not work) - Seek cover. If no alternative firearm or lethal force options are available proceed as follows: lock the slide open; release / strip the magazine; look and clear the feed path; if clear, open action reload, re-assess and proceed with your goal; if obstructed, clear obstruction, reload; reassess and proceed with your goal.

When done properly, clearing a stoppage may result in an undetonated round being ejected onto the floor/ground. Fishery Officers are reminded not to immediately pick up undetonated rounds cleared during a stoppage. Once it is safe to do so, undetonated ammunition is to be picked up and separated from spent 9mm casings, secured and marked as damaged ammunition, and returned to the armoury for proper destruction. Officers should not be holding these undetonated rounds in their hands shortly after firing and must not place them in their trouser pockets.

Fishery Officers are reminded to follow the Canadian Firearms Safety Rules (the vital four A.C.T.S.):

1. Assume every firearm is loaded
2. Control the muzzle direction at all times
3. Trigger finger must be kept off the trigger and trigger guard.

Armes à feu -- Désenrayer une arme à feu

Bien que les retards d'allumage ne soient pas fréquents, il est important de déterminer la marche à suivre lorsqu'une arme à feu s'enraye. Comme dans les procédures de la formation au tir, les trois étapes progressives pour débloquer un pistolet enrayé ayant pour objectif d'améliorer la rapidité d'exécution en situation tactique sont les suivantes :

- **Étape I** -- taper agressivement sur le chargeur afin de s'assurer qu'il est bien logé; tirer la glissière vers l'arrière agressivement, en utilisant une prise par-dessus et relâcher; réévaluer et procéder vers l'objectif.
- **Étape II** (en cas d'échec de l'étape I) - se mettre à couvert ou tenter de se faire plus petit; prendre ou récupérer un nouveau chargeur; extraire le chargeur de l'arme à feu, utiliser le nouveau chargeur, si nécessaire, pour sortir le premier chargeur; insérer le nouveau chargeur; tirer la glissière vers l'arrière agressivement; et réévaluer.
- **Défaillance mécanique** (si les étapes I et II ne fonctionnent pas) - se mettre à couvert. Si aucune autre arme à feu ou solution permettant la force létale n'est disponible, respecter la procédure suivante : verrouiller la glissière en position ouverte; relâcher ou retirer le chargeur; vérifier et dégager le trajet d'alimentation; une fois le trajet d'alimentation dégagé, ouvrir le mécanisme de recharge, réévaluer et procéder vers l'objectif.

Lorsque l'opération est effectuée correctement, le dégagement du blocage permet d'éjecter la munition non explosée. Nous rappelons aux agents des pêches de ne pas ramasser immédiatement le projectile non explosé qui a été éjecté de l'arme qui s'était enrayée. Lorsqu'il est sécuritaire de le faire, les munitions non explosées doivent être ramassées et séparées des douilles de 9 mm vides, pour ensuite être désarmées et marquées comme des munitions endommagées avant d'être retournées au dépôt afin qu'elles y soient détruites adéquatement. Les agents ne doivent pas tenir les munitions non explosées dans leurs mains peu de temps après les avoir éjectées et ils ne doivent pas les mettre dans les poches de leur pantalon.

Les agents des pêches doivent se conformer aux règles pour le maniement sécuritaire des armes à feu (les quatre règles vitales T. P. T. O.) :

1. Traiter toute arme à feu comme si elle est chargée.
2. Pointer toujours votre arme à feu dans une direction sécuritaire.
3. Tenir le doigt éloigné de la détente, sauf pour faire feu.

4. See that the firearm is unloaded- Prove safe (Peek and Poke) - follow firearms training instructions at all times, and treat firearms as if they are loaded and maintain muzzle control when clearing stoppages.

4.Ouvrir le mécanisme et s'assurer que l'arme à feu ne contient aucune munition -- prouver que l'arme à feu est sécuritaire. Respecter les consignes de la formation sur le maniement des armes à feu en tout temps et traiter toute arme à feu comme si elle était chargée, contrôler la direction du canon pendant le dégagement d'un blocage.

Distribution

This Enforcement Bulletin will be distributed to all Fishery Officers.

Enquiries regarding this publication should be directed to the Chief, Enforcement Policy and Standards, Conservation and Protection Directorate, Ecosystem and Fisheries Management.

Distribution

Le présent Bulletin d'application des règlements serra distribué à tous les agents des pêches.

Toutes demandes de renseignements concernant cette publication doivent être adressées au Chef, Politiques et normes d'application des règlements, Direction Générale de Conservation et Protection, Gestion des écosystèmes et des pêches

original signed by/original signé par
Directeur général
Trevor Swerdfager
Director General
Conservation and/et Protection

Fisheries and Oceans Canada | Pêches et Océans Canada

Enforcement Bulletin - Bulletin d'application des règlements

FIREARM AND AMMUNITION STORAGE REQUIREMENTS

EXIGENCES RELATIVES A L'ENTREPOSAGE DES ARMES A FEU ET DES MUNITIONS

2011-06-06

Purpose

In accordance with the Conservation and Protection (C&P) Firearms Policy and Procedures, I am accountable for all departmental firearms issued to Fishery Officers. While C&P has an exemplary record in firearms safety, I am required to remind all staff on an annual basis of the requirements for proper storage of weapons.

Background

Section 53 (1.2) of the Firearms Policy, specifically requires an annual written reminder on the safe storage practices for unrestricted, restricted and prohibited firearms, along with ammunition. **In this context I am requesting that each of you review the current Firearms Policy and Procedures (Sections 43.1 to 51), in order to refamiliarize yourself specifically with the procedures for safe storage that we have in place.**

While we have an exceptional safety record, we have, on a few occasions in the past, had firearms related incidents. In that context, I urge you to continue to be vigilant in the pursuit of the care, maintenance and safety of Departmental firearms and ammunition.

I can assure you that C&P management is committed to maintaining a high level of firearms training and proficiency. I would also take this opportunity as we enter our peak season to wish you a safe and productive summer and to thank you for your professional service to the department and to Canadians.

Objet

Selon la Politique et les procédures sur les armes à feu de Conservation et Protection (C et P), je dois rendre compte de toutes les armes à feu attribuées à des agents des pêches du MPO. Même si C et P a un dossier exemplaire pour ce qui est de la sûreté du traitement des armes à feu, une fois l'an, j'ai l'obligation de rappeler à tous les membres du personnel les règles d'entreposage approprié des armes à feu.

Contexte

L'article 53 (1.2) de la Politique sur les armes à feu exige l'envoi annuel d'un avis écrit pour rappeler les règles d'entreposage sécuritaire des armes à feu non restreintes, à autorisation restreinte et prohibées, et de leurs munitions**. Dans ce contexte, je demande à chacun de vous d'examiner la Politique et les procédures relatives aux armes à feu (Articles 43.1 à 51), afin d'en prendre connaissance et plus particulièrement de vous familiariser de nouveau avec les procédures d'entreposage sécuritaire en vigueur.**

Même si notre dossier en matière de sécurité est exceptionnel, des incidents liés à des armes à feu se sont produits à quelques occasions dans lepassé. Je vous invite donc à continuer à faire preuve de vigilance dans le traitement, l'entretien et la manutention sécuritaire des armes et des munitions du Ministère.

Je puis vous assurer que la direction de C et P est résolue à maintenir un haut niveau de formation et de compétence en ce qui a trait aux armes à feu. Enfin, je profite de l'arrivée de la haute saison pour vous souhaiter un été sécuritaire et productif, ainsi que pour vous remercier de votre professionnalisme au service du Ministère et des Canadiens.

Distribution

This Enforcement Bulletin will be distributed to all Fishery Officers.

Enquiries regarding this publication should be directed to the Chief, Enforcement Policy and Standards, Conservation and Protection Directorate, Ecosystem and Fisheries Management.

Distribution

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Toutes demandes de renseignements concernant cette publication doivent être adressées au Chef, Politiques et normes d'application des règlements, Direction Générale de Conservation et Protection, Gestion des écosystèmes et des pêches

original signed by/original signé par
Directeur général
Trevor Swerdfager
Director General
Conservation and/et Protection

Cormie, Mya

From: Pelletier, Katherine
Sent: Friday, June 17, 2011 12:43 PM
To: Sjodin, Chad; Thexton, David; McDonald, Bruce; Cormie, Mya
Cc: Matheson, Terry; Jobin, Jacques
Subject: FW: Safairland Model 518 Holster

Importance: High

Attention,

Can you all check if you have this holster and submit to Bruce.

Bruce..document what you have collected and return for the unit rather than each all individually to Richard as per email.

Thanks

From: Elson, Richard
Sent: June 16, 2011 1:01 PM
To: XPAC FM C&P FO ONLY
Cc: Bruinsma, Sid; Berthier, Jacinta; Poirier, Gerald - NHQ
Subject: Safairland Model 518 Holster

Fishery Officers-

As a result of an unintentional discharge that occurred last week the safe functioning of the Safariland Model 518 covert holster has been reviewed. Upon reviewing the design and function of this holster it was revealed that it is possible for the top flap to become inserted between the trigger and the trigger guard while re-holstering. If the flap remains between the two, the pistol discharges as it is inserted deeper into the holster. These were the circumstances we believe lead to the unintentional discharge.

As such we are recalling all Safariland Model 518 holsters currently in use. There very well may be none as this is a covert holster listed as approved for II&S members only. If you have one, please send to me.


0701_s[1].jpg


518_s[1].jpg

Photos showing the approved GD holster (0701) and the Model 518.

The wording in the approved equipment list is as follows:

Concealment Belt Holster

c) Safariland, Model 0701, Safarilaminate, Black, Thermal Plastic

(for short-term, plain clothes belt carry by normally uniformed officer – not recommended for undercover, SIU or GIS use)

Note: This is the only plainclothes belt holster approved for use by officers working in plain clothes who are not regular members of SI units.

Concealment Holster
f) Northern Plains, Model 14 PCAT, Black or Brown, Moulded Leather with available magazine holders, [SLM, IWB, DSU SMU, SMA Series]
- as per RCMP specifications -
[Recommended]
g) Bianchi, Model 4597, Ranger Shadow II, Black, Ballistic Nylon
with available magazine holders, OCS holders, handcuff pouch [Accumold Series]
[Recommended]
h) Safariland, Model 518, Paddle Thumb Break, Black, Safarilaminate, Thermal Plastic with available magazine holders, handcuff pouch, [models 673, 079 & 81] **(*n/b for S&W 5946 only)**

We are working on a training strategy for the use of concealment holsters and will work towards addressing any shortfalls in equipment or training needs. The approved holster (0701) is available from R. Nichols or MD Charlton.

Rich

Rich Elson
Senior Compliance Program Officer | Agent sénior, programme de conformité
Conservation & Protection / Direction du conservation et protection
Pacific Region / Région du Pacifique
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Fishery Officer Career Information / Information sur la carrière d'agent des pêches : http://www.dfo-mpo.gc.ca/officer-agent/

Deschênes, Marc

De: Chouinard, John
Envoyé: 9 janvier 2012 13:22
À: Perron, Daniel; Deschênes, Marc
Objet: TR: Firearms Incident Report_Summary / Incident lié à une arme à feu_sommaire de l'enquête

Hello / Bonjour,

As discussed at the last C&P Executive Committee Meeting, a summary report has been prepared following the investigation of an unintentional discharge of a firearm. The summary includes the key findings and recommendations related to equipment, training, and policy.

Please review the report and respond back indicating whether or not you support the recommendations as noted in the report, or if you would like to suggest additional action items. Since the agenda for the next C&P Executive Committee meeting will likely be a full one, I would appreciate your comments no later than January 20, 2012 so that we can move forward with approved recommended action items in this report.

Finally, I would ask that circulation of this report be limited to C&P Directors and Regional Firearms Officers only.

Any questions, please let me know.

Firearms Incident Investigatio...

Sommarie d'enquete_ Incid...

Thanks / Merci,

Jacinta

Jacinta Berthier
Chief, Enforcement Policies and Standards | Chef, Politique et normes d'application des règlements
Conservation and / et Protection
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Firearms Incident Investigation _ Review Board Findings

Unintentional Discharge of a Firearm during a Surveillance Training Course

In October 2011, an investigation was undertaken pursuant to Section 85 of the Firearms Policy and Procedures in relation to an unintentional discharge of a sidearm. The discharge occurred during a training course delivered by the Regional Conservation & Protection branch that included the use of concealment ~~firearm~~ holsters. The purpose of this investigation was to determine the adequacy of current firearms training, ~~related~~ policies ~~and procedures,~~ and enforcement equipment being provided to Fishery Officers.

The Investigation Team reported its findings in relation to the unintentional discharge (UD) in an investigation report submitted to the Director General on November 10, 2011. ~~Subsequently,~~A ~~a~~ brief summary of the findings was provided at the C&P Executive Team meeting on November 22-23, 2011, with a written summary ~~and it was determined that a summary of~~of the investigation's findings ~~report, with~~ along with ~~recommendations for~~ action to follow.~~next steps would be provided to the Executive Team.~~

A Review Board was convened on December 20, 2011, including the lead investigator for investigation team, Gerald Fillatre, Norm Smith, Regional Firearms Officer for Maritimes Region, Gerald Poirier, Chief, Recruitment and Training, and Jacinta Berthier, Chief, Enforcement Policy and Standards. This report provides the summary of findings, as well as the Review Board's recommendations to address the gaps and deficiencies identified in national C&P policies, procedures, training and equipment standards.

Background:

The unintentional discharge occurred ~~on~~ in late spring, ~~May 30th,~~ 2011 ~~in Pacific Region~~ and was reported to C&P National Headquarters on June 16, 2011: the report included a brief summary of the incident including an initial conclusion as to the immediate causes. The summary was provided in the form of the hazardous occurrence incident report (HOIR) submitted to the ~~regional~~ Occupational Health and Safety Committee by the Regional Firearms Officer. ~~It stated the immediate cause of the UD was two-fold: firstly, the officer was not formally trained on the use of the concealment (covert) holster; and secondly, the equipment design was such that when the officer holstered the firearm, the top flap of the holster was inserted between the trigger and trigger guard and the pressure applied to insert the firearm caused the trigger to depress and the firearm to discharge. Fortunately, there were no injuries.~~

~~The Pacific~~Subsequently, the Regional Firearms Officer circulated a note to all regional staff to cease use of the ~~recalling the~~ covert holster model 518, since it was thought the equipment directly contributed to the UD. Upon receipt of this message, National Headquarters circulated a similar message to all Regional Firearms Officers, directing that they too immediately recall this model (518) holster, and suspend its use in the field pending further investigation.

The use of concealment holsters as enforcement equipment is guided by the National Approved Equipment List, revised version 2011-04-01: ~~. T~~ the list ~~of approved equipment~~ currently has only one (1) approved model for general duty fishery officers who work in plain clothes. This model (#701) is most similar to the duty holster, the significant difference being the absence of a top flap. There are three other approved concealment holsters for use by special investigation units: the model 518 was approved for the latter group. Finally, it should be noted there are no national training standards or

requirements for the use of any concealment holsters. ~~; however, the approved model for general duty fishery officers is similar to the approved duty belt model, having a similar draw and holstering method, less the top flap.~~

Summary of Findings

Equipment

The Investigative Team noted the following findings in relation to the adequacy of the equipment used for plain clothes enforcement activities:

i). The concealment holster used by the general duty Fishery Officer during was approved only for members of the special investigative unit. The Officer worked in a detachment that is co-located with a special investigations unit ~~(now called the Intelligence and Investigation Services unit)~~. At the time of the incident, the detachment locker included outdated and unapproved equipment. The holster was given to the Officer by his Supervisor a few days prior to his attendance at a regional t~~Rural Surveillance~~raining c~~C~~ourse.

ii). Most witnesses interviewed could not differentiate between approved equipment for general duty officers versus that for specialized units. Furthermore, the approved equipment list for general duty Fishery Officers does not include any of the accoutrements for the concealment holster use, i.e. magazine holder, pepper spray, baton, handcuffs, while ~~those~~ some models approved for specialized units include such accoutrements.

~~iii).~~ While Section 73 of the Firearms Policy & Procedures (FPP) requires recovery of a firearm following discharge in certain cases, t~~T~~he firearm was not recovered ~~was not recovered~~ following the~~e~~ UD, and the holster was not available for inspection by the Team. ~~While Section 73 of the Firearms Policy & Procedures (FPP) requires recovery of a firearm following discharge in certain cases, it cannot be confirmed that the firearm did not malfunction, since it was not inspected following the discharge. Further, the specific holster in question was not available for inspection by the investigation team.~~

iii).

iv). Neither the members of the ~~investigation t~~Team, nor the firearms instructors interviewed as witnesses were able to recreate the UD ~~under the conditions in place at the time of the incident~~. Since the firearm was not tested and the incident could not be recreated, the Investigative Team was unable to determine the cause of the discharge with a high level of confidence.

Mise en forme : Puces et numéros

Training

The Investigative Team noted the following findings in relation to the adequacy of the training procedures in place for plain clothes enforcement activities:

i). Prior to the incident no one interviewed as part of the investigation (including the investigators) ha~~v~~ed taken part in training involving the ~~d received departmental training on the~~ use of concealment holsters. The investigation also revealed a potential gap in shotgun training related to the use of a single point sling to carry the firearm during the Rural Surveillance Course (RSC).

ii). The officer had no ~~was not trained, nor was he~~ familiarity with the concealment holster. The incident occurred the first time he used the holster. There is no prerequisite for the RSC course and it is unclear if any selection criteria are applied to the selection of participants. The officer had not worked plain clothes duties in the last 15 years.

iii). ~~There is no prerequisite training for the RSC course and it is unclear if any selection criteria are applied to the selection of participants.~~ Although the RSC is not a firearms course, firearm manipulation is required for holstering of firearms; it was noted that there was no designated safe zone set up for officers to load and holster their firearms.

iv). ~~RSC instructors do not confirm that course participants bring only approved equipment to the course. Further, the joining instructions and "required kit and equipment list" for the RSC were not consistent in specifying the "approved" concealment holsters.~~

Firearms Policy and Procedures (FPP)

The Investigative Team noted the following findings in relation to the adequacy of the policy and procedures in place in relation to this incident:

i). Amongst those interviewed, there was a low level of understanding as to the requirements for reporting unintentional discharges that occur in a training environment. Further, it was clear that the individuals involved found it difficult to interpret and follow the procedures in the FPP with regard to discharges.

ii). The use of unit specific names (e.g. SIU) seems to be problematic for some staff to interpret the national list of approved equipment for ~~some~~ staff.

iii). The reporting requirements in the FPP ~~are limiting~~require clarification. In particular, ~~, in that~~ there is no requirement ~~of~~ for the RFO to follow up reports made under section 78 ~~of the FPP~~ beyond the Regional Director General (RDG)~~RDG~~, i.e. the DG of C&P is not part of that reporting cycle. Further, it was unclear if the RDG ~~Regional Director General (RDG)~~ was notified of the discharge as per section 78(a) of the FPP by the region, before the . ~~The~~ DG C&P ~~did notify~~notified the RDG via the Terms of Reference for the Incident Investigation.

iv). The U/D was reported to DFO National headquarters approximately two weeks after the event; it was reported to identify an equipment malfunction not to identify the unintentional discharge as required under the FPP.

Conclusions of the Investigative Team

It is the determination of the Investigative team that there were a number of contributing factors which lead to the unintentional discharge on May 30th 2011, in particular:

A major contributing factor to this event is the fact that C&P lacks specific direction and opportunity for officers to be exposed to concealed carry equipment, such as holsters, in a controlled training setting.

- ~~Fisheries & Oceans Canada does not have a training course to train officers on the proper usage of concealed carry equipment such as holsters.~~
- Other factors that ~~led~~ contributing to the incident ~~event~~ are that the officer received his holster within a week of the course and ~~had a~~ lacked ~~of~~ recent plainclothes experience; although the officer was using an unapproved holster he was unfamiliar with a concealed holster of any type.
- ~~Staff, including those at the supervisory and instructor levels, were~~Staff, including those at the supervisory and instructor levels, was unaware of what was ~~considered to be~~ approved

Mis en forme : Police :12 pt

equipment for usage in relation to plain clothes versus special investigations unit ~~and undercover~~ duties.

- Since the officer's firearm and holster were not recovered after the incident, the Investigative Team was not able to assess the condition of the equipment, and was th~~. Th~~erefore unable~~, they were not able~~ to conclusively determine what caused the unintentional discharge ~~with certainty~~.

Review Board Recommended Course of Action ~~from the Review Board~~

The recommended actions are~~is~~ intended to provide assurances that the risk of such an incident reoccurring are ~~minimized~~mitigated~~,~~ and that Fishery Officers have the proper equipment, training and policy guidance to effectively perform their duties.

~~Recommendation #1 – Policy:~~

1. ~~Plain clothes / surveillance policy direction – includes guidance for using concealment holsters.~~
2. ~~Firearms Policy and Procedures – amend to clarify reporting procedures, and steps to follow in the case of accidental discharge of firearms.~~

Recommendation #~~2~~ 1 Equipment:

a) Assign a responsible authority for e~~E~~quipment inventories and control ~~– assign responsible authority to manage equipment and notify staff of approved equipment~~; purge unapproved equipment; ensure officers are familiarized with equipment and know how to use it before it is issued or checked out~~checked out~~.

b) Amend National ~~approved~~ Approved ~~equipment~~ Equipment ~~list~~ List ~~to be amended so it is~~following assessment of ~~clearer; assess~~ equipment requirements for plain clothes work in general duty ~~versus~~ and specialized work units~~, including I&IS~~.

Recommendation #~~3~~ 2 Training:

a) Short-term -Prior to field utilization of approved enforcement equipment such as ~~i.e.~~ concealment holsters, officers must be given the opportunity to practice with that equipment in a controlled training environment, under the guidance of a qualified Force Continuum instructor.

~~1.~~ Long-term-~~Once concealment holsters have been selected, a training program should be developed to familiarize fishery officers with the holster and any alternate methods of carrying enforcement equipment (e.g. magazine / cuffs / OCS / baton, as required).~~

b) ~~Any~~ Identify requirements for officer and ~~d~~ instructor training programs.

Recommendation #3 Policy:

a) Short-term- Develop Plain Clothes / Surveillance policy direction, including guidance for using concealment holsters and other use of force equipment. (Question: Should plain clothes work continue before policy direction is given? The risk is the lack of direction and consistency in carrying other use of force equipment in plain clothes work environments.)

b) Amend the Firearms Policy and Procedures to clarify reporting procedures, and steps to follow in the case of accidental discharge of firearms.~~related to firearms equipment, policy, etcetera.~~

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Mise en forme : Puces et numéros

Mis en forme : Default, Numéros + Niveau : 1 + Style de numérotation : a, b, c, … + Commencer à : 1 + Alignement : Gauche + Alignement : 0,25" + Tabulation après : 0,5" + Retrait : 0,5"
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Mise en forme : Puces et numéros

Mis en forme : Police :Arial, Couleur de police : Rouge
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Mise en forme : Puces et numéros

Enquête sur un incident lié à une arme à feu _ Conclusions du comité d'examen

Décharge involontaire d'une arme à feu lors d'un cours de formation sur la surveillance

En octobre 2011, une enquête a été entreprise à la suite de la décharge involontaire d'une arme courte, conformément à la section 85 du document *Politique et procédures sur les armes à feu*. La décharge s'est produite lors d'un cours de formation donné par la Direction générale régionale de la conservation et de la protection. Le cours comprenait l'utilisation d'étuis à pistolet dissimulés. L'objectif de l'enquête était de déterminer si la formation sur les armes à feu et les politiques actuelles sont convenables, ainsi que d'évaluer si l'équipement servant aux activités d'application de la loi fourni aux agents des pêches est adéquat.

L'équipe d'enquêteurs a présenté ses conclusions relativement à la décharge involontaire dans un rapport d'enquête remis au directeur général le 10 novembre 2011. Un résumé des conclusions a été présenté lors de la réunion de l'équipe de la haute direction de C et P les 22 et 23 novembre 2011, puis un résumé écrit des conclusions de l'enquête a été fourni ainsi que des recommandations quant aux mesures à prendre.

Un comité d'examen a été convié le 20 décembre 2011. Les membres comprenaient Gerald Fillatre, chef enquêteur de l'équipe d'enquêteurs, Norm Smith, préposé régional aux armes à feu pour les Maritimes, Gerald Poirier, chef, Recrutement et formation, et Jacinta Berthier, chef, Politique et normes d'applications des règlements. Ce rapport fournit le résumé des conclusions, ainsi que les recommandations du comité d'examen en vue de corriger les lacunes et les anomalies relevées dans les politiques nationales de C et P et les procédures, ainsi que dans les normes relatives à la formation et à l'équipement de C et P.

Contexte :
La décharge involontaire s'est produite à la fin du printemps de 2011 et a été signalée à l'administration centrale nationale de C et P le 16 juin 2011. Le rapport comprenait un résumé de l'incident, puis une première conclusion quant aux causes immédiates. Le résumé a été présenté sous forme de rapport d'enquête de situation comportant des risques (RIEH) fourni au comité de santé et sécurité au travail par le préposé régional aux armes à feu. Parallèlement, le préposé régional aux armes à feu a envoyé un avis à tous les membres du personnel régional les avisant de ne plus utiliser le modèle 518 d'étui dissimulé puisqu'il a été établi que l'équipement aurait contribué directement à la décharge involontaire. À la réception de ce message, l'administration centrale nationale a envoyé un avis similaire à tous les préposés régionaux aux armes à feu les avisant du rappel immédiat de ce modèle d'étui (518) et la suspension de son utilisation sur le terrain jusqu'à ce qu'une enquête plus approfondie soit menée.

L'utilisation d'étuis dissimulés en tant qu'équipement servant aux activités d'application de la loi est visée par la liste nationale d'équipement approuvé, revue le 1er avril 2011. La liste ne contient qu'un (1) seul modèle approuvé pour les agents des pêches du service général en civil. Ce modèle (n° 701) est celui qui ressemble le plus à l'étui de service, la grande différence étant l'absence d'un rabat supérieur. Trois autres étuis dissimulés sont approuvés pour les unités d'enquêtes spéciales : le modèle 518 a été approuvé pour ce groupe. Finalement, il faut prendre en compte le fait qu'il n'existe aucune norme ni exigence nationale relativement à l'utilisation des étuis dissimulés.

Résumé des conclusions

Équipement

L'équipe d'enquêteurs a tiré les conclusions suivantes relativement à l'adéquation de l'équipement utilisé pour les activités d'application de la loi menées par le personnel en civil :

i). L'étui dissimulé utilisé par l'agent des pêches du service général avait été approuvé uniquement pour les membres des unités d'enquêtes spéciales. L'agent travaillait pour un détachement dont l'emplacement est partagé avec celui d'une unité d'enquêtes spéciales. Au moment de l'incident, l'armoire-vestiaire du détachement contenait des pièces d'équipement désuètes et non approuvées. L'étui avait été remis à l'agent par son superviseur quelques jours avant sa participation au cours de formation régional.

ii). La plupart des témoins interrogés ne pouvaient différencier l'équipement approuvé pour les agents du service général de celui approuvé pour les unités spécialisées. De plus, la liste d'équipements approuvés pour les agents des pêches du service spécial ne comprend aucun attribut destiné à l'étui dissimulé (par exemple, chargeur, bonbonne de poivre de cayenne, bâton, menottes), alors que certains modèles approuvés pour les unités spéciales comprennent de tels attributs.

iii). Bien que la section 73 du document *Politique et procédures sur les armes à feu* exige dans certains cas la récupération des armes après une décharge, l'arme n'a pas été récupérée après l'incident et l'étui n'était pas à la disposition de l'équipe aux fins d'inspection.

iv). Aucun membre de l'équipe ni instructeur pour les armes à feu interrogé en tant que témoin n'était en mesure de recréer la décharge involontaire. Puisque l'arme à feu n'a pas été testée et que l'incident n'a pu être récréé, l'équipe d'enquêteurs n'a pas été en mesure de définir la cause de la décharge de façon non équivoque.

Formation

L'équipe d'enquêteurs a tir. les conclusions suivantes relativement à l'adéquation des procédures de formation pour les activités d'application de la loi menées par le personnel en civil :

i). Avant l'incident, aucun des membres interrogés lors de l'enquête (dont les enquêteurs) n'avait participé à une formation comprenant l'utilisation d'étuis dissimulés. L'enquête a également révélé une lacune potentielle relativement à la formation de tirs quant à l'utilisation d'une bretelle à point unique pour le transport d'arme lors du cours sur la surveillance rurale.

ii). L'agent n'avait jamais utilisé l'étui dissimulé. L'incident s'est produit la première fois qu'il a utilisé l'étui. Le cours sur la surveillance rurale n'exige aucune qualification préalable et il n'a pas été clairement établi que des critères de sélection sont appliqués lors du choix des participants. L'agent n'avait pas travaillé en civil ces 15 dernières années.

iii). Bien que le cours sur la surveillance rurale ne soit pas axé sur les armes, la manipulation de celles-ci est nécessaire pour le rangement dans l'étui. Il a été remarqué qu'aucune zone désignée n'était prévue pour que les agents puissent charger leur arme et la ranger dans leur étui en toute sécurité.

Politique et procédures sur les armes à feu

L'équipe d'enquêteurs a tiré les conclusions suivantes relativement à l'adéquation de la politique et des procédures en place relativement à cet incident :

i). Selon les réponses des personnes interrogées, les exigences relatives à la déclaration des décharges involontaires se produisant lors d'une formation sont mal comprises. De plus, il était manifeste que les personnes concernées avaient de la difficulté à interpréter et à suivre les procédures concernant les décharges qui sont décrites dans le document *Politique et procédures sur les armes à feu*.

ii). Pour certains membres, l'utilisation de titres propres aux unités (par ex., UES) semble causer un problème quant à l'interprétation de la liste nationale d'équipement approuvé pour le personnel.

iii). Les exigences en matière de déclaration décrites dans le document *Politique et procédures sur les armes à feu* doivent être clarifiées. Plus particulièrement, l'agent des pêches régional doit signaler l'incident suivant les échelons jusqu'au directeur général régional uniquement, conformément à la section 78, c'est-à-dire que le directeur général de C et P est tenu à l'écart du cycle de déclaration. De plus, il est difficile de déterminer si le directeur général régional a été avisé de la décharge par la région, conformément à la section 78*a*) du document *Politique et procédures sur les armes à feu*, avant que le directeur général de C et P ne l'en avise, conformément au cadre de référence de l'enquête sur l'incident.

iv). La décharge involontaire a été signalée à l'administration centrale nationale du MPO environ deux semaines après l'évènement; le rapport a été fait pour signaler la défaillance d'un équipement et non la décharge involontaire, bien que cela soit exigé en vertu du document *Politique et procédures sur les armes à feu*.

Conclusions de l'équipe d'enquêteurs

Les membres de l'équipe d'enquêteurs ont convenu que de nombreux facteurs ont contribué à la décharge involontaire survenue le 30 mai 2011, plus particulièrement :

L'un des facteurs ayant contribué à l'évènement est le fait que C et P ne fournit pas de directives particulières et ne donne pas la possibilité aux agents de manipuler régulièrement de l'équipement de transport dissimulé, tel que des étuis, dans un environnement de formation contrôlé.

- D'autres facteurs comprennent le fait que l'agent avait reçu son étui moins d'une semaine avant le cours et qu'il n'avait pas travaillé en civil depuis longtemps. Bien que l'agent ait utilisé un étui non approuvé, il n'avait jamais utilisé d'étui dissimulé.
- Le personnel, dont les superviseurs et les instructeurs, ne pouvait différencier l'équipement approuvé pour le service en civil de celui destiné aux unités d'enquêtes spéciales.
- Puisque l'arme de l'agent et son étui n'ont pas été récupérés après l'incident, l'équipe d'enquêteurs n'a pas été en mesure d'évaluer l'état de l'équipement, et n'a donc pas pu établir une cause définitive pour la décharge involontaire.

Mesures recommandées par le comité d'examen

Les mesures recommandées visent à faire en sorte que le risque associé à la récurrence d'un tel incident soit atténué et que les agents des pêches possèdent un équipement adéquat, reçoivent une

formation appropriée et soient orientés par une politique juste afin de pouvoir exercer leurs fonctions de façon efficace.

Recommandation 1 _ Équipement :

a) Affecter une personne responsable à l'inventaire et au contrôle de l'équipement. L'équipement non approuvé doit être éliminé. Il faut veiller à ce que les agents connaissent l'équipement et sachent s'en servir avant que celui-ci leur soit remis ou prêté.
b) Modifier la liste nationale d'équipement approuvé conséquemment à l'évaluation des exigences relatives à l'équipement pour le service en civil des membres du service général et des membres des unités spécialisées.

Recommandation 2 _ Formation :

a) Court terme - Avant l'utilisation sur le terrain de l'équipement servant aux activités d'application de la loi, comme les étuis dissimulés, les agents doivent avoir eu l'occasion de manipuler l'équipement dans un environnement de formation contrôlé, avec l'aide d'un instructeur qualifié du recours à la force progressive.
b) Long terme - Déterminer les exigences relativement aux programmes de formation des agents et des instructeurs.

Recommandation 3 _ Politique :

a) Court terme - Élaborer des directives sur les activités en civil ou de surveillance, y compris des instructions relatives à l'utilisation d'étuis dissimulés et d'autre équipement servant à l'application de la loi. (Question : Est-ce que le service en civil devrait se poursuivre avant que les directives ne soient élaborées? Le risque découle du manque de directives et d'uniformité relativement au transport d'autre équipement servant à l'application de la loi dans le cadre du travail en civil.)
b) Modifier le document *Politique et procédures sur les armes à feu* afin de clarifier les procédures de déclaration et les étapes à suivre dans l'éventualité d'une décharge accidentelle d'une arme à feu.

Hudema, Ronnie

From: Elson, Richard
Sent: Thursday, June 6, 2013 8:37 AM
To: Reich, Alex; Correia, Allan; Guptill, Beth; Wattie, Brad; Atagi, Brian; Sjodin, Chad; Clattenburg, David; Koshowski, Denise; Andriatz, Derek; Plummer, Greg; Davey, Jason; Hansen, Jim; Higgins, Linda; Crottey, Michael; Fraser, Mike; Powers, Perry; Christiansen, Richard; Elson, Richard; Hudema, Ronnie; Kish, Stan; Cartwright, Stu; Poole, Tom; Larson, Wade; Harris, Rob
Subject: Fw: IMPORTANT: Reminder for RFO and BFI when a misfire occurs at a Firearms Range.

Importance: High

From: Bruinsma, Sid
Sent: Thursday, June 06, 2013 09:59 AM Eastern Standard Time
To: Elson, Richard; Fillatre, Gerald; Deschênes, Marc; Smith, Norman (C&P); Scott, Kenneth; Doiron, Raymond
Cc: Ragetli, Henri L; Dwyer, Judy; Poirier, Gerald - NHQ; Gregoire Gascon <gregoire.gascon@rcmp-grc.gc.ca>; Tony Powaschuk <Tony.Powaschuk@rcmp-grc.gc.ca>; Richard Poaps <richard.poaps@rcmp-grc.gc.ca>
Subject: IMPORTANT: Reminder for RFO and BFI when a misfire occurs at a Firearms Range.

Good morning everyone. There was a recent misfire at a range using a DFO S&W 5946 and practice ammunition. This was not an unintentional discharge but a misfire. Since a misfire could be either an ammunition or firearm issue, care should be taken after the misfire. FOs must follow all instruction as to clearing the firearm and maintain control until it is proven safe. If the issue is stated that it was a misfire and not an unintentional discharge, the firearm is to be taken out of service immediately and sent to RCMP for investigation/inspection and a letter enclosed as to circumstance of the misfire. The Fishery Officer can finish shooting with a spare firearm. Also the RFO/BFI will advise NHQ of the circumstances of the misfire and any reported injuries in a timely fashion. The RFO/BFI in charge of the range will secure the spent casing and magazine used as this may provide valuable evidence as to the reason for the misfire. **DO NOT DISASSEMBLE THE FIREARM**. It may be difficult to ascertain the problem if the RFO/BFI takes the firearm apart and unknowingly changes the characteristics which may have caused the misfire. The firearm will be sent to RCMP armour's shop once NHQ has been notified of the misfire so that any issues can be tracked.

This process is for misfires only. Not for broken or poorly maintained dirty guns which may have a mechanical failure. These can be cleared at the range and inspected to see if the firearm is operational for the shoot. It is advised that if a firearm is suspected of having any problem which could affect its operational readiness it should be sent in for servicing immediately and the FO issued a replacement firearm. Remember if a firearm has an issue, let the RCMP know when it is sent in by including a note with the shipment. Do not just say it need servicing, this will help the RCMP build a knowledge base of issues related to this type of firearm in DFO.

This note should be forwarded to all operational BFIs in your region, and if you have any questions please do not hesitate to contact me immediately.

Cheers,

Sid Bruinsma
Senior Staff Officer / Agent fonctionnel principal
Enforcement Policies, Procedures and Standards/
Politiques, procédures et normes d'application des règlements
Conservation and Protection Directorate/
Direction Générale de Conservation et Protection
Fisheries and Oceans Canada / Pêches et Océans Canada
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200, rue Kent, pièce 13W124, Ottawa (Ontario)
K1A 0E6

Gratton, Valerie

From: Gordon, Graham
Sent: Monday, February 9, 2015 10:45 AM
To: Poirier, Gerald - NHQ; Bruinsma, Sid
Subject: FW: negligent discharge
Attachments: Negligent Discharge of Firearm during annual shotgun requalifications.docx

GP

A range incident at the PRCT last week. Fortunately as trained, the officer was pointing the firearm in a safe direction at all times, there were no injuries. I spoke to Rich about this weekend and all the recommendations in this document will be implemented in the Pacific Region. This is why we need consistency Nationally other regions may already have these recommendations in place.

Cheers

Graham Gordon
Program Officer, Recruitment and Training | Agent de programme, recrutement et formation
Conservation & Protection Directorate
Fisheries and Oceans Canada | Pêches et Océans Canada
200 Kent St. | 200, rue Kent
Ottawa, Ontario

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Cell: 613-410-7816
Facsimile: 613-941-2718

http://www.dfo-mpo.gc.ca/officer-agent/Officer-Agent_e.htm

http://www.dfo-mpo.gc.ca/officer-agent/Officer-Agent_f.htm

From: Elson, Richard
Sent: 2015–February-07 4:30 PM
To: Gordon, Graham
Subject: FW: negligent discharge

All recommendations have been addressed.

From: Fraser, Mike
Sent: February 6, 2015 7:19 PM
To: Elson, Richard
Cc: Reich, Alex; Harris, Rob; Clattenburg, David; Andriatz, Derek
Subject: negligent discharge

Rich,
Please find attached a brief report outlining a negligent discharge that occurred during shotgun qualifications at PRTC on Feb 5th, 2015.

This is a draft compiled from my notes so please accept further input from Alex, Rob, Dave or Derek if they wish to add or clarify any of the information. I will be on leave now returning Feb 17

Thanks

Mike Fraser
Fishery Officer
F.V.E. Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622
Email: Mike.Fraser@dfo-mpo.gc.ca

Negligent Discharge of Firearm during annual shotgun re-qualifications

Date of occurrence: Feb 5th, 2015

Location of Occurrence: RCMP range at the Pacific Region Training Center Chilliwack BC

Candidate: [redacted]

Line Officer: Derek Andriatz

Range Officer: Dave Clattenburg

Summary of Incident:

On stage 2 of the DFO bear shotgun course of fire at the 15 Meter mark when instructed to depress the trigger on an empty shotgun to prepare to load for bear, [redacted] discharged one round (slug) into the ground approximately 5 Meters in front of him in the direction of the target. The Muzzle was pointed in a safe direction so the discharge did not result in any damage or injury. There was a short pause in the training while the Range Officer and Line Officers verified that everything was ok and then the qualification process was slowed down and communication improved.

Instructors met to de-brief the incident and found the following contributing factors:

- Incident was at the end of a long day of training so fatigue levels were present in both candidate and Instructors
- Candidate was not aware that he had an extra round in the shot gun
- Candidate seemed to be unclear with respect to directions
- Instructors did not have a step by step lesson plan for calling out the commands for the DFO bear COF
- Noise levels were high from heavy rain on a canvass roof which made communications difficult
- Double hearing protection made it harder to hear commands
- Line officer was unfamiliar with the course of fire and due to the limited ability to communicate; the candidate was not instructed to open his shotguns action between stages.
- Limited shotgun understanding and skill of the candidate due to insufficient training, instruction, and practice.
- Instructors did not have adequate time to complete the scheduled training for the day.

Recommendations:

- Develop and include a step by step lesson plan for calling out the commands for the DFO bear COF for the instructor package
- Ensure Range Officers and Line Officers have adequate communication and are clear in their roles and expectations. (Pre briefing)
- Instructors and candidates should have more long-gun practice on a separate day to become more proficient with the shotgun.
- For this year, provide a separate range day for shotgun and rifle training as to not cram too much training into one day. This will allow more hands on training with the shotgun prior to live fire drills.
- Clear hand signals from LO's after shot gun is verified unloaded (action open) by Line Officer prior to moving forward on the range.

Government of Canada
Fisheries and Oceans

Gouvernement du Canada
Pêches et Océans

PROTECTED A
CCGMS # 2015-702-00099
EKME # 3490019

To: Wendy Watson-Wright
Pour: Regional Director General

Date: JUN 30 2015

Object: **HUMANE DESTRUCTION OF A DEER**
Objet:

From / De: Edmond Martin — Director, Conservation and Protection

Via: Andrew Maw — Regional Director, Fisheries and Aquaculture Management

Additional approvals:
Autre(s) approbation(s):

☐	Your Signature Votre signature	☒	nformation
☐	For Comments Observations	☐	Material for the Minister Documents pour le Ministre

Remarks:
Remarques:

DISTRIBUTION

Drafting Officer/ Rédacteur: LEGRESLEY, Jean-Claude (506-851-7800) / EM / ch

Fisheries and Oceans Canada
Pêches et Océans Canada

Fisheries and Aquaculture Management
Gestion des pêches et de l'aquaculture

PROTECTED A

2015-702-00099
EKME # 3490019

MEMORANDUM FOR THE REGIONAL DIRECTOR GENERAL

HUMANE DESTRUCTION OF A DEER
(FOR INFORMATION)

SUMMARY OF ADVICES TO REGIONAL DIRECTOR GENERAL

The purpose of this memo is to inform you that, as per section 78(a) of the Firearms Policy and Procedure, a Fishery Officer (FO) discharged his firearm against other than at a person (deer) (Tab 1).

On June 19, 2015, FO Craig MacDonald of the Pictou Detachment was approached by members of the public and informed of an injured deer.

Upon locating the deer, FO MacDonald determined that the deer should be destroyed in order to prevent it from further suffering as per section 71(1)(b) of the Firearms Policy and Procedure (Tab 2).

The deer was subsequently destroyed in a humane manner with two rounds.

BACKGROUND

On June 19, 2015, FO Craig MacDonald was approached and informed by members of the public about an injured deer in the Wallace River region of Nova Scotia.

FO MacDonald reports that the deer in question was badly injured.

FO MacDonald humanely destroyed it with his sidearm to prevent its further suffering as per section 71(1)(b) of the Firearms Policy and Procedure.

.../2

Canada

STRATEGIC CONSIDERATIONS: POLICY DEVELOPMENT

In order to prevent the deer from any further suffering, FO Craig MacDonald humanely destroyed a badly injured deer. This was done in accordance with the Firearms Policy and Procedure.

Members of the public and other stakeholders might have reacted negatively should the injured deer be left to suffer and eventually die on its own.

By humanely destroying the deer in order to prevent its further suffering, negative reactions from members of the public and other stakeholders have been averted.

INTRADEPARTMENTAL CONSULTATIONS

Having been flagged down by members of the public on this injured deer, Fishery Officer's communication with the Department of Natural Resources (DNR) confirmed they were unable to respond in a timely manner.

INTERDEPARTMENTAL CONSULTATIONS

There were no interdepartmental consultations in the preparation of this note.

ADVICE AND RECOMMENDATIONS TO REGIONAL DIRECTOR GENERAL

Fishery Officers must continue to follow the Firearm Policy and Procedure when dealing in situations involving suffering animals.

FO Craig MacDonald acted in accordance with the Firearm and Procedure when he prevented a deer from further suffering by humanely destroying it with his sidearm.

for Andrew Maw
Andrew Maw
Regional Director
Fisheries and Aquaculture Management

Attachments (2)
Tab 1 – Section 78 (a)
Tab 2 – Section 71 (1) (b)

2015-702-00099– Humane Destruction of a Deer
Jean-Claude LeGresley, 51-7800, Senior Compliance Program Officer / EM /ch
506-8

Fishery Officer Supervisor [Discharge/Point at a Person]

77. Where a Fishery Officer Supervisor is made aware that a Fishery Officer intentionally pointed or discharged a firearm at a person that Fishery Officer Supervisor shall, as soon as possible, report the incident, verbally and in writing[63]
    (a) to the police of local jurisdiction[64]
    (b) through channels, to the Regional Director General; and
    (c) to the Regional Firearms Officer.

[Discharge Other Than at a Person]

78. Where a Fishery Officer Supervisor is made aware that a Fishery Officer discharged an approved firearm, other than at a person, that Fishery Officer Supervisor shall, as soon as possible, report the incident, verbally and in writing
    (a) through channels, to the Regional Director General; and
    (b) to the Regional Firearms Officer.

---

63 For the purpose of this section and section 78., Fishery Officer Supervisor includes the FOIC or the Patrol Vessel Master, as may be applicable)

64 In the case of a Fishery Officer intentionally pointing or discharging a firearm while at sea, the police of local jurisdiction are the police whose jurisdiction includes the area where; (a) the occurrence took place, (b) the detachment from which the Fishery Officer was operating is located, (c) the home port of the patrol vessel from which the Fishery officer was operating is located, or (d) the port to which the patrol vessel from which the Fishery Officer was operating first lands after the occurrence.

Tab 2

71. (1) Subject to subsection (2) no Fishery Officer shall discharge an approved firearm at any animal unless that Fishery Officer believes that animal to be
(a) a danger to human life;
(b) so sick or badly injured that it should be destroyed to prevent its further suffering; or
(c) an animal that should be destroyed in accordance with provincial law and that Fishery Officer is so authorised by that provincial law.

(2) A Fishery Officer in an emergency survival situation may discharge an approved firearm at an animal where it is necessary to take the animal for sustenance.

[Discharge with Injury]

72. Where a Fishery Officer discharges a firearm and that discharge results in injury to a person that Fishery Officer shall render first aid to those persons injured and seek medical assistance as soon as possible.

71. (1) Subject to subsection (2) no Fishery Officer shall discharge an approved firearm at any animal unless that Fishery Officer believes that animal to be
(a) a danger to human life;
(b) so sick or badly injured that it should be destroyed to prevent its further suffering; or
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[Discharge with Injury]

72. Where a Fishery Officer discharges a firearm and that discharge results in injury to a person that Fishery Officer shall render first aid to those persons injured and seek medical assistance as soon as possible.

s.19(1)

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print**.

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage		Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/ Chemical Hazard		Visit to Doctor (no time loss)	
		First Aid Only	
Equipment Malfunction		No Injury (near miss)	X
Pressure Vessel		Other	

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
EFM	Langley	July 08, 2016

Mailing Address	Area/Program
5550 268 Street, Langley, BC Postal Code: V4W3X4	Conservation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Perry Powers	604-607-4163

C. EMPLOYEE DATA (if applicable)

Employee's Surname	Given Name	Initials
[redacted]		

Occupation

Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Langley Office – Gun room	July 6, 2016 2000 hrs	8 hours

Weather conditions at the time of the occurrence:
NA

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties perfonned at the time of the hazardous occurrence?
Yes _____ No___x___
Specify:

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

Unintentional discharge while performing a draw and point exercise. See attached report by employee.

F. IMMEDIATE CAUSES

In this section please identify substandard practices and/or substandard conditions if any:

Unknown at this time. The pistol is being sent to the RCMP armoury for examination and inspection which will determine if the pistol is defective in any way. The employee advised that she felt her hand placement may have resulted in ineffective control of the pistol and that attempting to regain that control may have resulted in her finger grasping the trigger. If this is the case, when she squeezed the grip to regain control, her trigger finger in all probability involuntarily squeezed in unison with her other fingers resulting in a round being fired.

G. BASIC CAUSES

In this section please identify personal, environmental and/or job/system factors:

Unknown at this time if the employee had ineffective grasp of the pistol grip or if the pistol malfunctioned.

H. WITNESSES (if more please attach information)

Witness #1 - Name NA	Telephone #:	Witness #2 - Name	Telephone #:
Witness #3 - Name	Telephone #:	Witness #4 - Name	Telephone #:

I. CORRECTIVE & PREVENTIVE MEASURES

Corrective measures taken and/or recommended to prevent recurrence
Will wait for recommendations as a result of the investigation.

J. SUPPLEMENTARY PREVENTATIVE MEASURES

Responsibility for corrective action assigned to:	Date to be completed	Follow-up date
Unknown at this time.		

K. PROPERTY DAMAGE

Nature & extent of property damage	Estimated Loss ($)
No property damage other than a bullet hole in the shelf against a cement wall.	NA

L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Perry Powers	604-607-4163	Perry Powers

Manager's comment:
Notification of event sent through chain of command as required in the Firearms Policy.

Follow-up by management necessary re: evaluating the practise of drawing and pointing as part of a daily ritual at the beginning of a shift, and at the end of a shift prior to unloading and storing duty pistol.

Name of OSH Committee Member / OSH Representative	Telephone #	Signature
Rob Harris	604-892-3254	R Harris

OSH Committee Member / Representative comment

s.19(1)

Gallant, Nicole

From: Green, Ken
Sent: Friday, July 8, 2016 2:51 PM
To: Elson, Richard; Powers, Perry
Cc: Gallant, Nicole; Redekopp, Herb; Hlavac, Thomas
Subject: RE: Incident Report-Unintentional Discharge

Hi Rich,

I went out to Langley today to talk [redacted] I told Perry to get her back into field duties. In my opinion I think there should be a re-thinking of encouraging Fishery Officers who are unloading at the end of their shift to draw and punch out as if they were responding to a deadly threat. I understand the theory behind this practice but I believe it contributed to the accidental discharge. In my 23 years of carrying a pistol on the job at the end of a shift I always focused on safely drawing my pistol and carefully unloading it in a safe manner. My complete attention is focused on that specific task. Drawing my pistol to respond to a deadly threat is a completely different thing and is not affected by the way I unload at the end of a shift. I recommend that yourself and the Chiefs and Director have a discussion on the "punching out" unloading procedure as I personally feel it should be discontinued and that Fishery Officers be instructed to simply make their pistols safe without turning it into a tactical exercise which I believe is increasing the possibility of accidental discharge.

Thanks,

Ken Green

C & P Supervisor
Fisheries and Oceans Canada/Government of Canada
ken.green@dfo-mpo.gc.ca / Tel: 604-664-9251

Superviseur C&P
Pêches et Océans Canada/Gouvernement du Canada
ken.green@dfo-mpo.gc.ca / Tél: 604-664-9251

From: Elson, Richard
Sent: Friday, July 08, 2016 9:24 AM
To: Powers, Perry
Cc: Green, Ken; Gallant, Nicole; Redekopp, Herb; Elson, Richard; Hlavac, Thomas
Subject: RE: Incident Report-Unintentional Discharge

Unless there is a reason not to..... We want to immediately give her another pistol. I understand the potential trauma and embarrassment with regards to this but if there is no reason not to, we what her to continue on with regular duties.

I will send this up the line as per policy and we will see what NHQ says and we may have to prepare further documentation but will cross that path when we need to. [redacted]

Rich

Sent: July-07-16 6:06 PM
To: Elson, Richard
Cc: Green, Ken; Gallant, Nicole; Redekopp, Herb
Subject: FW: Incident Report-Unintentional Discharge

Rich, one of our officers, [redacted] had an unintentional discharge at the end of her shift. She was following the practise of drawing and punching out. [redacted] was following the guidance provided by firearms instructors. I note that this practise is done just before unloading and storing the firearm. The firearm was pointed in a safe direction (safe wall) so there was no danger to anyone else. In this case [redacted] was the only person present at the time of the incident. [redacted]

I have taken possession of the firearm for the moment and await further instructions on how to proceed from here.

The incident has already been reported through chain of command as per policy.

I can be reached at the e-mail address and telephone number below or on my cell at [redacted]

Perry Powers

A/Detachment Supervisor
Fishery Officer / Field Supervisor, Conservation And Protection
Fisheries and Oceans Canada / Government of Canada
Perry.Powers@dfo-mpo.gc.ca / Tel : 604-607-4163

Agent des pêches / Superviseur sur le terrain, Conservation et protection
Pêches et Océans Canada / Gouvernement du Canada
Perry.Powers@dfo-mpo.gc.ca / Tél :604-607-4163

[redacted]

Gratton, Valerie

From: Poirier, Gerald - NHQ
Sent: Monday, July 11, 2016 8:45 AM
To: Bruinsma, Sid
Cc: Gordon, Graham
Subject: FW: Incident Report-Unintentional Discharge
Attachments: Firearm Discharge.doc

FYI

Gérald Poirier
gerald.poirier@dfo-mpo.gc.ca
613-990-0115

From: Elson, Richard
Sent: July 8, 2016 12:31 PM
To: Laking, Erin
Cc: Poirier, Gerald - NHQ
Subject: FW: Incident Report-Unintentional Discharge

Erin although not in policy at this moment...further policy on this issue will likely include the national chief of POR so....I send to you FYI.

Rich

From: Elson, Richard
Sent: July-08-16 9:29 AM
To: Poirier, Gerald - NHQ; Dwyer, Judy
Subject: FW: Incident Report-Unintentional Discharge

I will get further details on this incident but likely as a precaution we should send the firearm into Depot for a complete inspection.

Last service date of her issued pistol was Dec of 2009.

Rich

From: Powers, Perry
Sent: July-07-16 6:06 PM
To: Elson, Richard
Cc: Green, Ken; Gallant, Nicole; Redekopp, Herb
Subject: FW: Incident Report-Unintentional Discharge

Rich, one of our officers, [redacted] had an unintentional discharge at the end of her shift. She was following the practise of drawing and punching out. [redacted] was following the guidance provided by firearms instructors. I note that this practise is done just before unloading and storing the firearm. The firearm was pointed in a safe direction (safe wall) so there was no danger to anyone else. In this case [redacted] was the only person present at the time of the incident. [redacted]

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Agent des pêches / Superviseur sur le terrain, Conservation et protection
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[redacted]

Wednesday July 6, 2016 at approximately 2000 hrs

[redacted] The day of the discharge I again worked my scheduled shift of noon to 8:00pm.

I was alone in my office gun room to store my firearm and belt after my shift. As instructed by my firearm instructors, every day after my shift I draw my gun, punch out and aim as if I would on a target. I remember drawing my firearm in a safe direction against the back wall and then being shocked by hearing it fire. It has been over 12 hours since the incident where I have spent the majority of that time trying to clearly remember or understand how it happened. I am still [redacted] uncertain as to how this could have happened.

What I do know without a doubt is that when I drew my gun my index finger was on the frame. I have [redacted] muscle memory to automatically put my finger to frame every time I draw. From day one in depot firearms to my following years on the range I have never had to be reminded or reprimanded for not doing this. [redacted] I have put my finger to frame when un-holstering without fail. One thing that I am certain of is that my finger was on the frame when I drew my gun on July 6th. What I can remember about that evening is when I drew my firearm I felt that my grip was off, meaning that my right hand, the hand I draw with did not get its usual placing on the grip. I remember that my hand was too far forward on the grip and that it was a fast draw. How that may or may not have contributed to my firearm discharging I do not know.

[redacted] I put the gun down, unloaded it and placed the firearm on the table before opening the gun room door knowing that someone would be coming. Dave Clattenburg came in and asked what happened, I told him I didn't know. That I remember un-holstering and then hearing it go off. Shortly after he asked me again and I told him I had no idea but that I did remember thinking that my grip on the gun was all wrong. He wondered if I might have lost my hold on the gun and in trying to stop myself from dropping it I caught the trigger and set it off. I honestly don't know how it happened but do not believe that is what occurred. However it happened I know that it happened quick and that I remember feeling nervous before it went off [redacted]

[redacted] it was an incredibly unlucky fluke of quick events that lead to the accidental discharge of my firearm.

Powers, Perry s.19(1)

From: Powers, Perry
Sent: Tuesday, July 12, 2016 9:59 AM
To: Elson, Richard
Subject: RE: HOIR

[redacted]

Perry

From: Elson, Richard
Sent: 2016-July-12 9:55 AM
To: Powers, Perry
Subject: RE: HOIR

Makes sense!!

[redacted]

Rich

Can you forward the HOIR or has it been signed off yet?

From: Powers, Perry
Sent: July-12-16 9:53 AM
To: Elson, Richard
Subject: RE: HOIR

An HOIR is done.

The hole is at [redacted]eye level.

Perry

From: Elson, Richard
Sent: 2016-July-11 2:08 PM
To: Powers, Perry
Subject: HOIR

Did we do an HOIR for the AD?

How high on the wall was the bullet impact?

Thanks

Rich Elson
Chief, Recruitment,Training and Standards/Chef, Recrutement, Formation et Normes
Conservation and Protection / Conservation et Protection
Pacific Region / Région du Pacifique
Fisheries and Oceans Canada / Pêches et Océans Canada
Government of Canada / Gouvernement du Canada
Phone / Téléphone: (250) 561-5510
Facsimile / Télécopieur:(250) 561-5534

Cell: (250) 961-8874
Email / Courriel: Richard.Elson@dfo-mpo.gc.ca

Fishery Officer Career Information / Information sur la carrière d'agent des pêches : http://www.dfo-mpo.gc.ca/officer-agent/

Fisheries and Oceans
Perry Powers
5550 268 Street
Langley, BC
V4W 3X4

Pacific Region

s.19(1) Pêches et Océans

July 27, 2016

Armourer
R.C.M.P. Depot
Building 98
Dewdney Ave West
Regina, Sask. S4T 1E1

Subject: **FISHERIES AND OCEANS PISTOL FOR INSPECTION AFTER AN UNINTENTIONAL DISCHARGE.**

Enclosed find pistol serial number [redacted] and three duty magazines. The ammunition that was present in the firearm at the time of the discharge will be sent seperately. The spent shell casing was discarded prior to the request to include it.

Please also service the pistol as it has not ben done since 2009.

Return all to sender.

Sincerely,

Perry Powers
Field Supervisor
Ph. 604-607-4150
Fax. 604-607-4199

Canada

Gallant, Nicole

From: Elson, Richard
Sent: Wednesday, October 12, 2016 8:12 AM
To: Gallant, Nicole; Redekopp, Herb
Cc: Poirier, Gerald - NHQ; Hlavac, Thomas
Subject: Green - Unintentional Discharge

I just confirmed with the armourer that the firearm has not been inspected yet but they will hopefully do it today.

HOIR completed already so once the report from depot comes in I can provide the material to all and we can move forward on next steps

Rich

Rich Elson
Chief, Recruitment,Training and Standards/Chef, Recrutement, Formation et Normes
Conservation and Protection / Conservation et Protection
Pacific Region / Région du Pacifique
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Gallant, Nicole

From: Elson, Richard
Sent: Thursday, October 13, 2016 8:37 AM
To: Redekopp, Herb; Gallant, Nicole
Cc: Poirier, Gerald - NHQ
Subject: FW: Unintentional discharge_ [redacted] July 6, 2016

Thanks to Rob Harris for his follow up and Perry for participating in this process.

I will let you pass on those Nicole or Herb.

[redacted]

Rich

From: Hlavac, Thomas
Sent: October-13-16 8:29 AM
To: Elson, Richard
Subject: Fw: Unintentional discharge_ [redacted] _ July 6, 2016

Thank everyone for the efforts to address this one.

Thomas V Hlavac
A/Director, Conservation and Protection
Pacific Region
Department of Fisheries and Oceans
200-401 Burrard St.
Vancouver, BC V6C3S4

From: Reid, Rebecca <Rebecca.Reid@dfo-mpo.gc.ca>
Sent: Wednesday, October 12, 2016 18:32
To: Hlavac, Thomas
Cc: Poirier, Julie
Subject: RE: Unintentional discharge_ [redacted] July 6, 2016

Thank you Tom, I concur.

RR

Rebecca Reid
Regional Director General/ Directrice générale régionale
Fisheries and Oceans Canada - Pacific Region/ Pêches et Océans Canada - Région du Pacific
200-401 Burrard Street / 401, rue Burrard, bureau 200
Vancouver, BC/CB V6C 3S4
Office / Téléphone: 604-666-6098
Cell / Cellulaire: 604 323 6422
E-mail/ Courriel: rebecca.reid@dfo-mpo.gc.ca

From: Hlavac, Thomas
Sent: Wednesday, October 12, 2016 6:08 PM
To: Reid, Rebecca <Rebecca.Reid@dfo-mpo.gc.ca>
Subject: FW: Unintentional discharge_ _ July 6, 2016

Rebecca

The attached HOIR describes a negligent discharge. This type of incident is fairly serious as injury or death could occur (and also rare), but were prevented as we have an unloading procedure that in this case helped avoid a very negative outcome. The attached RCMP armourer's report indicates that the trigger must have been pulled, that there was no equipment failure.

As Rich notes, under the policy you have the option to seek further investigation. I concur with Rich that this is not necessary. The RTS (recruitment, training and standards) team have provided remedial instruction to (the officer involved). I also suspect strongly that the recent media on the Canadian Forces officer who caused a negligent discharge reinforced the lesson (the CF officer received a $2,000 fine after a court martial).

This incident also will generate even more attention during the requalification process (by demonstrating that accidents do happen and that the training has to take root). It will reverberate in the C&P community for a while as a reminder.

Tom Hlavac

From: Elson, Richard
Sent: October-12-16 2:22 PM
To: Gallant, Nicole; Redekopp, Herb; Hlavac, Thomas
Cc: Elson, Richard; Poirier, Gerald - NHQ; Clements, Brian
Subject: Unintentional discharge_ July 6, 2016

Attached find HOIR and RCMP armourers report. In my opinion Officer was responsible for the discharge. The most likely reason for the discharge is as noted in the HOIR. In an attempt to gain control of the firearm as she felt it slip, she depressed the trigger resulting in the discharge.

The issue of drawing and pointing to engrain the muscle memory upon drawing is taught in depot and an established training technique. The advantage of this is when you need to draw under stress you will do so with muscle memory and no time will be spend on the thinking part of the action. I do not believe this contributed to the incident as when properly done with your finger off the trigger a discharge cannot occur. I have re-in forced the procedure with to make sure she is completing this correctly and that it is done at a speed that is appropriate for the situation (drawing with the intent to unload and store firearm in the secure room).

My recommendation is that no further action take place. We have nothing to gain from an investigation under the Firearm Policy in my opinion. Although the policy is outdated it does specify that the RDG can call for further investigation. As such you should make Rebecca aware of it and ask her for concurrence.

Rich

Rich Elson
Chief, Recruitment,Training and Standards/Chef, Recrutement, Formation et Normes
Conservation and Protection / Conservation et Protection
Pacific Region / Région du Pacifique
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From: Redekopp, Herb
To: Ford, Leanne
Cc: Clements, Brian; Hlavac, Thomas
Subject: RE: HOIR - [redacted]2016-534-00078
Date: October-21-16 10:29:18 AM

[redacted]

I will resubmit a more serious HOIR

Herb Redekopp
Area Chief, DFO
Conservation and Protection
Lower Fraser Area
604-666-2807

From: Ford, Leanne
Sent: October-20-16 11:54 AM
To: Redekopp, Herb
Cc: Clements, Brian; Hlavac, Thomas
Subject: FW: HOIR - [redacted]2016-534-00078

Hi Herb – Please see the attached HOIR and email below. The RDG want's the HOIR re-done/reworded. Once completed please resubmit to Brian Clements. Thank you,

Leanne

From: Okahori, Karen
Sent: October-20-16 9:49 AM
To: Ford, Leanne
Subject: RE: HOIR - [redacted] 2016-534-00078

Hi Leanne,

I've included in his next bilat discussion, so no need to schedule a separate meeting.

In the meantime, the HOIR needs to be redone/reworded. RDG will not sign off as it is currently written.

Thanks.

Karen

From: Ford, Leanne
Sent: October 20, 2016 9:41 AM
To: Okahori, Karen
Cc: Ford, Leanne
Subject: FW: HOIR - [redacted] 2016-534-00078

Hi Karen – the RDG has asked to speak with Tom for 10 min max regarding the attached HOIR. Could

you let me know when she has a free moment to fit this in and send out a meeting invite?

Please advise. Thank you,

Leanne

From: Ivings, Juanita
Sent: October-18-16 8:45 AM
To: Ford, Leanne
Subject: RE: HOIR - [redacted]2016-534-00078

Thank you will resubmit for signature. Thank you.

Juanita

From: Ford, Leanne
Sent: October-18-16 8:33 AM
To: Ivings, Juanita
Subject: FW: HOIR - [redacted]2016-534-00078

FYI

From: Hlavac, Thomas
Sent: October-17-16 1:27 PM
To: Ford, Leanne
Subject: RE: HOIR - [redacted]2016-534-00078

[redacted]Nothing else needed, cost of doing business outdoors. I'll ask Herb during the conferece call, let Juanita know that if I hear anything, will pass on.

From: Ford, Leanne
Sent: October-17-16 11:16 AM
To: Hlavac, Thomas
Subject: FW: HOIR - [redacted]2016-534-00078

Hi Tom – Juanita is looking for a response on the questions below. Send the response directly to Juanita and cc me as well.

Thank you,

Leanne

From: Ivings, Juanita
Sent: October-13-16 9:26 AM
To: Hlavac, Thomas
Cc: Ford, Leanne; Ivings, Juanita
Subject: HOIR - [redacted]2016-534-00078

Tom see Rebecca's questions below on the above:

"Tom aside from telling [redacted] not to stand behind a rock that he is pulling on, is there something

else that is needed here? [redacted] RR"

If you could respond back to me I will make sure it is attached in the book for the HOIR to be signed off. Thank you for your assistance.

Juanita Ivings

Correspondence Coordinator
Fisheries and Oceans Canada / Government of Canada
Juanita.Ivings@dfo-mpo.gc.ca / Tel: 604-666-3303

Coordonnatrice de correspondence
Pêches et Océans Canada / Gouvernement du Canada
Juanita.Ivings@dfo-mpo.gc.ca / Tél: 604-666-3303

2019/05/13 Date 0715

OJ - level I investigations
- BFI - they operate based on their BFI RCMP training
- unfettered access to firearms by FO's
- could they have been picked up off the ground?
- need guidelines to "prevent" this from happening
* moving to orange only dummy rounds only

[redacted] +

SRKW conference call - RDG

* [redacted]

Harris, Rob

From: Harris, Rob
Sent: May-17-17 5:39 PM
To: Elson, Richard
Subject: Re: Firearms training

Dang....a HOIR? Ok.
When I get back to office.

From: Elson, Richard
Sent: Wednesday, May 17, 2017 5:38 PM
To: Harris, Rob
Subject: Re: Firearms training

Ha ha.....i get going to fast sometimes! Maybe when HOIR done you could pull out the drill from the lesson plan and attach.

Sent from my BlackBerry 10 smartphone on the Rogers network.

From: Harris, Rob
Sent: Wednesday, May 17, 2017 5:35 PM
To: Elson, Richard
Subject: Re: Firearms training

Pull what and send huh?

From: Elson, Richard
Sent: Wednesday, May 17, 2017 4:18 PM
To: Harris, Rob
Subject: RE: Firearms training

When you get a chance can you pull it out of the lesson plan and just send the section ..

From: Harris, Rob
Sent: May-17-17 4:02 PM
To: Elson, Richard
Subject: Re: Firearms training

[redacted]
Just grabbed flashlight and grabbed trigger at same time.
I de briefed with him, and we recreated the motion.....
[redacted]

From: Elson, Richard
Sent: Wednesday, May 17, 2017 3:47 PM
To: Harris, Rob
Subject: RE: Firearms training

[redacted]

From: Harris, Rob
Sent: May-17-17 3:43 PM
To: Elson, Richard
Subject: Re: Firearms training

[redacted]
Abbotsford Rod and Gun Club.
Range 1, indoor, low light lesson plan.

From: Elson, Richard
Sent: Wednesday, May 17, 2017 3:09 PM
To: Harris, Rob
Subject: RE: Firearms training

Name of officer?

Location of incident?

From: Harris, Rob
Sent: May-17-17 1:49 PM
To: Elson, Richard
Cc: Clattenburg, David
Subject: Firearms training

Hey Rich,
Just keeping you in the loop and making sure you get what you need.

On Monday May 15 during low light training we had an unintentional discharge on the indoor range.

During a supervised drill the officer unintentionally pulled the trigger of his pistol. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof.

The officer was being directly supervised by Line Officer Clattenburg, I was the Range Officer.

A cease fire was called and the incident was investigated. The range officials were notified, and inspected the damage. We will receive a bill for repair of one ceiling tile, a sheet of tin roofing and about 1hr labour.

If you need any further information or documentation please let me know and I will ensure it gets completed.

Otherwise training is going very well, with very good feedback from all participants.

Cheers!
Rob

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print.**

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage	x	Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/		Visit to Doctor (no time loss)	
Chemical Hazard		First Aid Only	
Equipment Malfunction		No Injury (near miss)	x
Pressure Vessel		Other	x

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
Ecology/Fisheries Management	Chilliwack Field Office	May 25, 2017

Mailing Address	Area/Program
#327 -44500 South Sumas Road Chilliwack B.C. Postal Code: V2R-5M3	Conversation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Mike Fraser A/Detachment Supervisor	604 824-3320

C. EMPLOYEE DATA (if applicable)

Employee's Surname		
DOUGLAS	ANTHOINY	

Occupation
Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Abbotsford Gun range	May 12 2017 at 1300 hours	3 hours

Weather conditions at the time of the occurrence:

Indoor range

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties performed at the time of the hazardous occurrence?
Yes _____ No__x_____
Specify:

No injury

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

On Monday May 15 during low light training we had an unintentional discharge on the indoor range.

During a supervised **training** drill the officer unintentionally pulled the trigger of his pistol **resulting in a discharge**. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof.

The officer was being directly supervised by Line Officer Clattenburg, I was the Range Officer.

TG comments – can you recall how many people were in the immediate vicinity of the training exercise
-what PPE was used
-what was the purpose of the low light training exercise
-are you aware if RTS reviewed this training drill and if so are they satisfied it is safe to continue
-outline the safety procedures you had in place (eg. Did you have an officer designated to provide first aid, call 911 etc)

F. IMMEDIATE CAUSES

In this section please identify substandard practices and/or substandard conditions if any:

During a supervised drill the officer unintentionally pulled the trigger of his pistol. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof.

The officer was being directly supervised by Line Officer Clattenburg, I was the Range Officer.

G. BASIC CAUSES

In this section please identify personal, environmental and/or job/system factors:

It was a low light firearms training exercise. The handling of a flashlight and firearm while maintaining continuity of a suspect. The exchange of the flashlight and the firearms technique was not as directed because it was a new technique. It was during this exchange that the firearm was discharged.

H. WITNESSES (if more please attach information)

Witness #1 - Name	Telephone #:	Witness #2 - Name	Telephone #:
Dave Clattenberg	604 607-4157		
Witness #3 - Name	Telephone #:	Witness #4 - Name	Telephone #:

I. CORRECTIVE & PREVENTIVE MEASURES

Corrective measures taken and/or recommended to prevent recurrence

An immediate cease fire and investigation took place as well as the proper technique for exchange was reviewed.

TG comments – please elaborate on what steps were taken (eg pistol was inspected, what additional training / instruction did you provide the officer)

TG comments – could I suggest that we offer the officer more training with the "red gun" before transitioning to the duty pistol? Is the risk level high enough to warrant that all this type of training should be done with the "red gun" first until techniques are mastered before transitioning to he duty pistol?

J. SUPPLEMENTARY PREVENTATIVE MEASURES

Responsibility for corrective action assigned to:	Date to be completed	Follow-up date
Rob Harris	May 31,.2017	June 01, 2017

K. PROPERTY DAMAGE

Nature & extent of property damage	Estimated Loss ($)
Replacement of ceiling tile and time of labour	$200.

L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Rob Harris	604 892-3254	
Manager's comment:		
Name of OSH Committee Member / OSH Representative	Telephone #	Signature
OSH Committee Member / Representative comment		

s.19(1)

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print**.

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage	x	Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/		Visit to Doctor (no time loss)	
Chemical Hazard		First Aid Only	
Equipment Malfunction		No Injury (near miss)	x
Pressure Vessel		Other	x

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
Ecology/Fisheries Management	Chilliwack Field Office	May 25, 2017

Mailing Address	Area/Program
#327 -44500 South Sumas Road Chilliwack B.C. Postal Code: V2R-5M3	Conversation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Mike Fraser A/Detachment Supervisor	604 824-3320

C. EMPLOYEE DATA (if applicable)

Employee's Surname	DOUGLAS	ANTHOINY	
			Occupation Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Abbotsford Fish and Game gun range 4161 Lakemount Rd, Abbotsford, BC V2T 6Z6	May 12 2017 at 1300 hours	3 hours

Weather conditions at the time of the occurrence:

Indoor range

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties performed at the time of the hazardous occurrence?
Yes _____ No_____
Specify: No Injury but safety briefing was provided

No injury

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

On Monday May 15 during low light firearms training there was an unintentional discharge of Fishery Officer [redacted] pistol on the indoor range.

During a supervised **training** drill the officer unintentionally pulled the trigger of his pistol **resulting in a discharge**. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof. Officer [redacted] new that his finger was on the trigger instead of on the frame of the pistol while he was conducting the technique and he knew right away what the cause of the unintentional discharge was. Range Officer Rob Harris came over and officer [redacted] holstered his firearm and informed Rob that he had his finger on the trigger while performing the technique and inadvertently squeezed the trigger as he seated the new magazine.

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer.

There were approximately 10 officers on line in the immediate area and all officers were wearing full uniform including body armour, hearing protection and eye protection.

The purpose of the low light training exercise was to provide critical Health and Safety training to officers who work regularly in low light environments. The goal of this training was to provide skills and practice time to allow officers to comfortably and confidently use their use of force tools (firearm) with a flashlight in a low light environment.

These drills were approved by Rich Elson Chief of RTS and had been taught and demonstrated to the Pacific Region firearms trainers during the Instructor training week in Comox in April 2017.

There were first aid attendants identified and first aid supplies on site with access to a vehicle to transport staff in the event of an accident.

Rob Harris informed the Abbotsfoprd Fish and Game club (Robert Engh) – rental coordinator- of the discharge and damage to the ceiling and roof that same day.

F. IMMEDIATE CAUSES

In this section please identify substandard practices and/or substandard conditions if any:

During a supervised drill the officer unintentionally pulled the trigger of his pistol. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof. Officer [redacted] new that his finger was on the trigger instead of on the frame of the pistol while he was conducting the technique and he knew right away what the cause of the unintentional discharge was. Rob Harris came over and officer [redacted] holstered his firearm and informed Rob that he had his finger on the trigger while performing the technique and squeezed the trigger as he seated the new magazine.

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer. As this was a low light drill it was difficult for the line officer to absolute control over every aspect of the training. Line Officer Clattenburg was able to see that all pistols were pointed in a safe direction and thus employees were protected from an unintentional discharge. The drills started in a lighted environment with an unloaded pistol for safety while learning the techniques and then progressed to a low light environment with a loaded pistol for the required training effect. Clearly the instruction to keep firearms pointed down range and in a safe direction was adhered to and prevented a potential serious accident.

G. BASIC CAUSES

In this section please identify personal, environmental and/or job/system factors:

It was a low light firearms training exercise. The handling of a flashlight and firearm while maintaining continuity of a suspect. The exchange of the flashlight and the firearms technique was not as directed because it was a new technique. It was during this exchange that the firearm was discharged do to the officer having his finger on the trigger instead of on the frame of the pistol

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer. As this was a low light drill it was difficult for the line officer to absolute control over every aspect but the drills start in a lighted environment for safety and then progress to a low light environment for the required training effect. As some of these drills were new it was clear that there was some confusion on the part of the participant and an unintentional discharge occurred. Clearly, the instruction to keep the firearms pointed down range and in a safe direction was adhered to and prevented a potential serious accident.

H. WITNESSES (if more please attach information)

Witness #1 - Name	Telephone #:	Witness #2 – Name	Telephone #:
Dave Clattenberg	604 607-4157	Robert Harris	604-892-3254
Witness #3 - Name	Telephone #:	Witness #4 - Name	Telephone #:

I. CORRECTIVE & PREVENTIVE MEASURES

Corrective measures taken and/or recommended to prevent recurrence

An immediate cease fire and investigation took place. Rob Harris and officer [redacted] moved into a lighted environment in the foyer of the range [redacted] further explained what had happened. Rob Harris then demonstrated the correct method for the technique and clarified that the finger needs to be on the frame of the pistol until the decision to shoot is made.

J. SUPPLEMENTARY PREVENTATIVE MEASURES

Responsibility for corrective action assigned to:	Date to be completed	Follow-up date
Rob Harris	May 31, 2017	June 01, 2017

K. PROPERTY DAMAGE

Nature & extent of property damage	Estimated Loss ($)
Replacement of ceiling tile, fix roof and time of labour	$1800.00.

L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Mike Fraser/Rob Harris	604 824-3320	MIKE FRASER FEBRUARY 16th, 2018

Manager's comment:

Mike Fraser Comment:
As a firearms instructor we know that we have multiple safety measures in place to prevent injury during firearms training. The fact that Officer [redacted] pistol was pointing in a safe direction was the most important factor during this training as it clearly prevented a potential serious accident. This is something that line officers are able to observe in a low light environment and clearly Line Officer Clattenburg was able to maintain the safety of the individuals under his supervision by ensuring all firearms remained pointed in a safe direction. Officer [redacted] immediately new the cause of the unintentionally discharge and was forth coming in explaining this to the Range officer who then provided remedial training. I am satisfied that appropriate measures were taken in this situation.

Name of OSH Committee Member / OSH Representative	Telephone #	Signature

OSH Committee Member / Representative comment

s.19(1)

Harris, Rob

From: Harris, Rob
Sent: May-26-17 9:31 AM
To: Elson, Richard
Subject: RE: Firearms training

Of course,
4 omni present rules, always at the start of the lecture.

As well as during teaching and demonstrating the skill.

I taught that drill of transferring the pistol and firearms. I actually laughed at myself because I said " keep you finger straight" and "finger on frame" over and over and over.
I was using positive reinforcement on telling them what to do, straight finger, finger to frame.
That and a dropped gun is a dropped gun.....over and over.

I demonstrated, over demonstrated the technique with exaggerated straight finger at all times.

He did not have his finger on the trigger to shoot or during shooting. When he grabbed his flashlight with hi support hand, while his pistol was in his support hand, all his fingers curled as in grasping and one of his fingers grasped the trigger as part of the flashlight.

He was attempting to grab the flashlight and pistol at the same time. It is possible that he did have a straight trigger finger and that another finger squeezed the trigger as he was squeezing to grasp the flashlight.

[redacted] has always had good control. I would believe that he may have had proper finger control but another finger may have squeezed the trigger while grasping the flashlight. He does have small thick fingers, and may have had just to much stuff in his hands.

Hope that helps,
You can call anytime.

Thanks

Robert Harris
Fishery Officer

Incident Report regarding dispatch of a wounded Seal

By Fishery Officer Joseph Knockwood

On Tuesday September 19th I Fishery Officer Joseph Knockwood of the Souris C&P detachment was tasked with checking the condition of a seal in the Campbell's Cove area. I was met by [redacted] we went down to the area where the Seal was and noticed that the Seal didn't move and was shivering and hardly breathing and had a couple of open wounds one its side another on his back. I identified the animal as a grey seal approximately 500 lbs+. The wounds and ears were bloody and looked as though the birds had been picking at them. We figured it may have been incidentally caught and released by a Tuna or Halibut Fisherman and the wounds may have been caused by a gaff or dart.

[redacted] who lived in the area stated that the seal was there for a few days and wasn't in very good shape and wasn't moving and looked very ill. I [redacted] and I made an assessment that the Seal was very distressed and should be dispatched. So as a result I dispatched the seal with 2 rounds to the head from my service revolver. I contacted my Supervisor Shane MacIsaac to let him know what I did and he told me to contact the province to let them know where it is so they could dispose of the carcass. I called Dave MacEwen who stated that they would take care of the disposition I gave him directions to the area.

Made a follow up call to Dave MacEwen a week later he stated that the Seal was gone and may have been washed out to Sea.

Fishery Officer Joseph Knockwood

Souris C&P

Knockwood, Joseph

From: MacIsaac, Shane
Sent: Wednesday, September 20, 2017 8:19 AM
To: Gillespie, Glen
Cc: Knockwood, Joseph
Subject: RE: Seal Dispatch

With staffing changes over the past few years we are unsure who the RFTO is....can you provide name?

From: Gillespie, Glen
Sent: Tuesday, September 19, 2017 4:30 PM
To: Knockwood, Joseph
Cc: MacIsaac, Shane
Subject: Seal Dispatch

Hi Joe,

Please prepare a written report and forward to your supervisor and the Regional Firearms Officer regarding your firearm discharge to dispatch a wounded seal under Section 71 (1) (b) of the firearms policy I understand you have already contacted the provincial authorities to remove the carcass. I have copied the applicable section below.

76. (1) Subject to subsection (2), where a Fishery Officer discharges an approved firearm pursuant to section 70 or 71 that Fishery Officer shall report the discharge, in writing, to that Fishery Officer's supervisor and the Regional Firearms Officer within fifteen working days of the discharge.
(2) Where a Fishery Officer wounds or destroys an animal pursuant to section 71 that Fishery Officer shall report that incident to the appropriate authorities, which may include provincial and municipal authorities, as soon as possible.

Thanks,

Glen Gillespie
Fishery Officer-Detachment Supervisor
Dept. of Fisheries and Oceans
Conservation & Protection
PO Box 1236, 165 John Yeo Drive
Charlottetown, PE
C1A 7M8
Phone- 902-566-7775
Cell- 902-214-0818
Fax- 902-626-4999

Gray, Trevor

From: Gray, Trevor
Sent: Wednesday, February 14, 2018 3:24 PM
To: Fraser, Mike
Cc: Sumi, Catherine; Carlson, Mike; Redekopp, Herb; Clements, Brian; Harris, Rob
Subject: Pacific Region HOIR - training incident at Abbotsford Gun Range in May 2017 (near miss)
Attachments: May 15 abby gun range-OSH HOIR.doc

Importance: High

Hi Mike,

I learned this afternoon that RTS did not complete the HOIR and subsequent investigation (other than what you and Rob initiated) for the incident at the Abbotsford Gun Range in May 2017 (Sherry confirmed with Rich). I have reviewed the HOIR that you initiated and would appreciate your help as follows:

-review the attached HOIR and consider my comments and update if appropriate. I recognize you are a subject matter expert but I may see things through a different lens
-update the wording to reflect 3rd person so we are clear who was doing what role
-it indicates we took supplementary measures which were assigned to Rob. Can you elaborate in the document what they were and if they have been completed
- please include a sentence that confirms the appropriate representative from the Abbotsford Gun Range was notified and who this individual is
-update the property damage estimate (I believe it was around $1600)
-sign the HOIR in the appropriate box (if Rob was assigned to investigate by the Manager then he should sign it)
-return to me to complete the Manager comments section. As Regional Firearms Officer I think it is appropriate for me to comment.
-provide me the name of the Health and Safety representative for the Chilliwack office. I will send it to them for their comments and signature once I provide my input.

This is somewhat time sensitive so I would appreciate it if you could have this updated and returned to me by Feb 21st.

Thanks for your help on this.

Trevor Gray
Chief of Recruitment, Training and Standards
Fisheries and Oceans Canada
Conservation & Protection – Pacific Region
401 Burrard St.
Vancouver, BC

Office (604) 775-8008
cell (778) 884-1349
e-mail: trevor.gray@dfo-mpo.gc.ca

Fishery Officer Career Information http://www.dfo-mpo.gc.ca/career-carriere/enf-loi/training-formation-eng.htm

From: Gray, Trevor
Sent: 2018–February-14 9:20 AM
To: Clements, Brian <Brian.Clements@dfo-mpo.gc.ca>
Cc: Arbo, Andrea <Andrea.Arbo@dfo-mpo.gc.ca>
Subject: Pacific Region HOIR - training incident
Importance: High

Hi Brian,

We had a firearms training incident in May of 2017 that I have just learned may not have been reported up through proper channels. Are you able to confirm if your office received a final copy of the investigation for me? The HOIR that I tracked down hasn't been investigated fully (see attachment).

If this incident wasn't reported properly, I will re-start the investigative process immediately.

Thanks for your help.

Trevor Gray
Chief of Recruitment, Training and Standards
Fisheries and Oceans Canada
Conservation & Protection – Pacific Region
401 Burrard St.
Vancouver, BC

Office (604) 775-8008
cell (778) 884-1349
e-mail: trevor.gray@dfo-mpo.gc.ca

Fishery Officer Career Information **http://www.dfo-mpo.gc.ca/career-carriere/enf-loi/training-formation-eng.htm**

From: Gray, Trevor
Sent: 2018–February-12 9:20 AM
To: Bruinsma, Sid <Sid.Bruinsma@dfo-mpo.gc.ca>
Subject: Pacific Region HOIR - training incident

Hi Sid,

Attached is the HOIR from the May firearms training incident at the indoor range in Abbotsford. I will attempt to track down the final signed off copy by the OSH group.

Thanks,
Trevor Gray

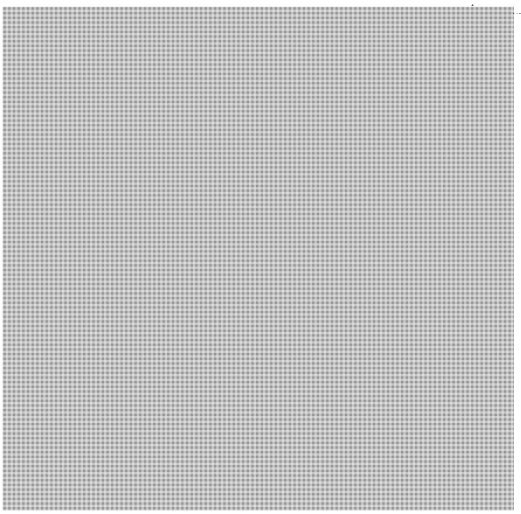
Sent: 2018–February-12 8:54 AM
To: McDonald, Sherry <Sherry.McDonald@dfo-mpo.gc.ca>; Gray, Trevor <Trevor.Gray@dfo-mpo.gc.ca>; Sumi, Catherine

<Catherine.Sumi@dfo-mpo.gc.ca>
Subject: FW: HOIR

Here is a copy of the HOIR dealing with the Abbotsford Range unintentional discharge before it was signed by Rich. Rob Harris was running the line and Dave Clattenburg was the assigned line officer during this incident.

Thanks

Mike Fraser
Fishery Officer
F.V.E. Detachment Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622
Email: Mike.Fraser@dfo-mpo.gc.ca



s.19(1)

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print**.

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage	x	Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/		Visit to Doctor (no time loss)	
Chemical Hazard		First Aid Only	
Equipment Malfunction		No Injury (near miss)	x
Pressure Vessel		Other	x

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
Ecology/Fisheries Management	Chilliwack Field Office	May 25, 2017

Mailing Address	Area/Program
#327 -44500 South Sumas Road Chilliwack B.C. Postal Code: V2R-5M3	Conversation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Mike Fraser A/Detachment Supervisor	604 824-3320

C. EMPLOYEE DATA (if applicable)

Occupation
Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Abbotsford Gun range	May 12 2017 at 1300 hours	3 hours

Weather conditions at the time of the occurrence:

Indoor range

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties performed at the time of the hazardous occurrence?
Yes _____ No_x_____
Specify:

No injury

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

On Monday May 15 during low light training we had an unintentional discharge on the indoor range.

During a supervised **training** drill the officer unintentionally pulled the trigger of his pistol **resulting in a discharge**. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof.

The officer was being directly supervised by Line Officer Clattenburg, I was the Range Officer.

TG comments – can you recall how many people were in the immediate vicinity of the training exercise
-what PPE was used
-what was the purpose of the low light training exercise
-are you aware if RTS reviewed this training drill and if so are they satisfied it is safe to continue
-outline the safety procedures you had in place (eg. Did you have an officer designated to provide first aid, call 911 etc)

F. IMMEDIATE CAUSES

In this section please identify substandard practices and/or substandard conditions if any:

During a supervised drill the officer unintentionally pulled the trigger of his pistol. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof.

The officer was being directly supervised by Line Officer Clattenburg, I was the Range Officer.

G. BASIC CAUSES

In this section please identify personal, environmental and/or job/system factors:

It was a low light firearms training exercise. The handling of a flashlight and firearm while maintaining continuity of a suspect. The exchange of the flashlight and the firearms technique was not as directed because it was a new technique. It was during this exchange that the firearm was discharged.

H. WITNESSES (if more please attach information)

Witness #1 - Name	Telephone #:	Witness #2 - Name	Telephone #:
Dave Clattenberg	604 607-4157		
Witness #3 - Name	Telephone #:	Witness #4 - Name	Telephone #:

I. CORRECTIVE & PREVENTIVE MEASURES

Corrective measures taken and/or recommended to prevent recurrence

An immediate cease fire and investigation took place as well as the proper technique for exchange was reviewed.

TG comments – please elaborate on what steps were taken (eg pistol was inspected, what additional training / instruction did you provide the officer)

TG comments – could I suggest that we offer the officer more training with the "red gun" before transitioning to the duty pistol? Is the risk level high enough to warrant that all this type of training should be done with the "red gun" first until techniques are mastered before transitioning to he duty pistol?

J. SUPPLEMENTARY PREVENTATIVE MEASURES

Responsibility for corrective action assigned to:	Date to be completed	Follow-up date
Rob Harris	May 31, 2017	June 01, 2017

K. PROPERTY DAMAGE

Nature & extent of property damage	Estimated Loss ($)
Replacement of ceiling tile and time of labour	$200.

L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Rob Harris	604 892-3254	
Manager's comment:		
Name of OSH Committee Member / OSH Representative	Telephone #	Signature
OSH Committee Member / Representative comment		

s.19(1)

Gray, Trevor

From: Fraser, Mike
Sent: Friday, February 16, 2018 3:23 PM
To: Gray, Trevor
Cc: Redekopp, Herb; Carlson, Mike; Clements, Brian; Sumi, Catherine; Harris, Rob
Subject: HOIR Abbotsford Range Incident May 2017
Attachments: May 15 abby gun range-OSH HOIR.doc

Trevor,
I have updated and expanded on this HOIR. Just to be clear I was not present during this incident and I was satisfied (from email correspondence from RTS) RTS had completed this investigation months ago. I spoke [redacted] today and updated some of the events from what he could re-call. Please let me know if there is anything further you require from me with respect to this matter.

Sincerely,

Mike Fraser
Fishery Officer
F.V.E. Detachment Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622
Email: Mike.Fraser@dfo-mpo.gc.ca

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print**.

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage	x	Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/		Visit to Doctor (no time loss)	
Chemical Hazard		First Aid Only	
Equipment Malfunction		No Injury (near miss)	x
Pressure Vessel		Other	x

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
Ecology/Fisheries Management	Chilliwack Field Office	May 25, 2017

Mailing Address	Area/Program
#327 -44500 South Sumas Road Chilliwack B.C. Postal Code: V2R-5M3	Conversation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Mike Fraser A/Detachment Supervisor	604 824-3320

C. EMPLOYEE DATA (if applicable)

[redacted]

Occupation
Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Abbotsford Fish and Game gun range 4161 Lakemount Rd, Abbotsford, BC V2T 6Z6	May 12 2017 at 1300 hours	3 hours

Weather conditions at the time of the occurrence:

Indoor range

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties performed at the time of the hazardous occurrence?
Yes _____ No_____
Specify: No Injury but safety briefing was provided

No injury

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

On Monday May 15 during low light firearms training there was an unintentional discharge of Fishery Officer [redacted] pistol on the indoor range.

During a supervised **training** drill the officer unintentionally pulled the trigger of his pistol **resulting in a discharge**. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof. Officer [redacted] new that his finger was on the trigger instead of on the frame of the pistol while he was conducting the technique and he knew right away what the cause of the unintentional discharge was. Range Officer Rob Harris came over and officer [redacted] holstered his firearm and informed Rob that he had his finger on the trigger while performing the technique and inadvertently squeezed the trigger as he seated the new magazine.

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer.

There were approximately 10 officers on line in the immediate area and all officers were wearing full uniform including body armour, hearing protection and eye protection.

The purpose of the low light training exercise was to provide critical Health and Safety training to officers who work regularly in low light environments. The goal of this training was to provide skills and practice time to allow officers to comfortably and confidently use their use of force tools (firearm) with a flashlight in a low light environment.

These drills were approved by Rich Elson Chief of RTS and had been taught and demonstrated to the Pacific Region firearms trainers during the Instructor training week in Comox in April 2017.

There were first aid attendants identified and first aid supplies on site with access to a vehicle to transport staff in the event of an accident.

Rob Harris informed the Abbotsfoprd Fish and Game club (Robert Engh) – rental coordinator- of the discharge and damage to the ceiling and roof that same day.

F. IMMEDIATE CAUSES

In this section please identify substandard practices and/or substandard conditions if any:

During a supervised drill the officer unintentionally pulled the trigger of his pistol. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof. Officer knew that his finger was on the trigger instead of on the frame of the pistol while he was conducting the technique and he knew right away what the cause of the unintentional discharge was. Rob Harris came over and officer holstered his firearm and informed Rob that he had his finger on the trigger while performing the technique and squeezed the trigger as he seated the new magazine.

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer. As this was a low light drill it was difficult for the line officer to absolute control over every aspect of the training. Line Officer Clattenburg was able to see that all pistols were pointed in a safe direction and thus employees were protected from an unintentional discharge. The drills started in a lighted environment with an unloaded pistol for safety while learning the techniques and then progressed to a low light environment with a loaded pistol for the required training effect. Clearly the instruction to keep firearms pointed down range and in a safe direction was adhered to and prevented a potential serious accident.

G. BASIC CAUSES

In this section please identify personal, environmental and/or job/system factors:

It was a low light firearms training exercise. The handling of a flashlight and firearm while maintaining continuity of a suspect. The exchange of the flashlight and the firearms technique was not as directed because it was a new technique. It was during this exchange that the firearm was discharged do to the officer having his finger on the trigger instead of on the frame of the pistol

The officer was being directly supervised by Line Officer Clattenburg, and Rob Harris was the Range Officer. As this was a low light drill it was difficult for the line officer to absolute control over every aspect but the drills start in a lighted environment for safety and then progress to a low light environment for the required training effect. As some of these drills were new it was clear that there was some confusion on the part of the participant and an unintentional discharge occurred. Clearly, the instruction to keep the firearms pointed down range and in a safe direction was adhered to and prevented a potential serious accident.

H. WITNESSES (if more please attach information)

Witness #1 - Name	Telephone #:	Witness #2 – Name	Telephone #:
Dave Clattenberg	604 607-4157	Robert Harris	604-892-3254
Witness #3 - Name	Telephone #:	Witness #4 - Name	Telephone #:

I. CORRECTIVE & PREVENTIVE MEASURES

Corrective measures taken and/or recommended to prevent recurrence

An immediate cease fire and investigation took place. Rob Harris and officer [redacted] moved into a lighted environment in the foyer of the range and [redacted] further explained what had happened. Rob Harris then demonstrated the correct method for the technique and clarified that the finger needs to be on the frame of the pistol until the decision to shoot is made.

J. SUPPLEMENTARY PREVENTATIVE MEASURES

Responsibility for corrective action assigned to:	Date to be completed	Follow-up date
Rob Harris	May 31, 2017	June 01, 2017

K. PROPERTY DAMAGE

Nature & extent of property damage	Estimated Loss ($)
Replacement of ceiling tile, fix roof and time of labour	$1800.00.

L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Mike Fraser/Rob Harris	604 824-3320	MIKE FRASER FEBRUARY 16th, 2018

Manager's comment:

Mike Fraser Comment:
As a firearms instructor we know that we have multiple safety measures in place to prevent injury during firearms training. The fact that Officer [redacted] pistol was pointing in a safe direction was the most important factor during this training as it clearly prevented a potential serious accident. This is something that line officers are able to observe in a low light environment and clearly Line Officer Clattenburg was able to maintain the safety of the individuals under his supervision by ensuring all firearms remained pointed in a safe direction. Officer [redacted] immediately new the cause of the unintentionally discharge and was forth coming in explaining this to the Range officer who then provided remedial training. I am satisfied that appropriate measures were taken in this situation.

Name of OSH Committee Member / OSH Representative	Telephone #	Signature

OSH Committee Member / Representative comment

Gray, Trevor

From: Fraser, Mike
Sent: Monday, February 26, 2018 9:19 AM
To: Shivji, Yasmin
Cc: Gray, Trevor; Clements, Brian
Subject: FW: HOIR from firearms training incident in May 2017
Attachments: Scanned from a Xerox Multifunction Printer.pdf

Importance: High

For your review and action.

Mike Fraser
Fishery Officer A/Field Supervisor
F.V.E. Detachment Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622
Email: Mike.Fraser@dfo-mpo.gc.ca

-----Original Message-----
From: Fraser, Mike
Sent: February-22-18 11:32 AM
To: Clements, Brian
Cc: Gray, Trevor
Subject: HOIR from firearms training incident in May 2017
Importance: High

Brian,
Please review this HIOR in relation to a firearms training incident from May 2017. There is some confusion as to why this was not forwarded sooner and we hope to resolve that in order to prevent reporting delays of this nature in the future.

Our OHS rep was not comfortable reviewing or signing this HOIR due to the time delay.

Please advise if I can be of further assistance.

Sincerely,

Mike Fraser
Fishery Officer A/Field Supervisor
F.V.E. Detachment Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622

Email: Mike.Fraser@dfo-mpo.gc.ca

-----Original Message-----
From: dfo.donotreply-nepasrepondre.mpo@canada.ca [mailto:dfo.donotreply-nepasrepondre.mpo@canada.ca]
Sent: February-22-18 6:37 PM
To: Fraser, Mike
Subject: Scanned from a Xerox Multifunction Printer

Please open the attached document. It was scanned and sent to you using a Xerox Multifunction Printer.

Attachment File Type: pdf, Multi-Page

Multifunction Printer Location: BC, Chilliwack, Chilliwack Hatchery, Floor 2, Room 327
Device Name: pmbccrhxxChilliwackHatcheryRoom327

For more information on Xerox products and solutions, please visit http://www.xerox.com

s.19(1)

FISHERIES AND OCEANS CANADA
HAZARDOUS OCCURRENCE INVESTIGATION REPORT

(revised February 8, 2001)

To be filled out by the responsible manager with assistance from the OSH Committee member or OSH Representative. Return to Safety and Health Unit, Corporate Resources. Please **print.**

A. TYPE OF OCCURRENCE

Explosion		Fatality	
Fire		Disabling Injury/time loss	
Property Damage	x	Loss of Consciousness	
Motor Vehicle		Emergency Procedure	
Environmental/		Visit to Doctor (no time loss)	
Chemical Hazard		First Aid Only	
Equipment Malfunction		No Injury (near miss)	x
Pressure Vessel		Other	x

NOTE: Consult the DFO Hazardous Occurrence Investigation and Reporting Procedures for reporting time frame and copy distribution requirement to central agencies.

B. GENERAL INFORMATION

Branch	Location	Date of Report
Ecology/Fisheries Management	Chilliwack Field Office	May 25, 2017

Mailing Address	Area/Program
#327 -44500 South Sumas Road Chilliwack B.C. Postal Code: V2R-5M3	Conversation and Protection

Responsible Supervisor's Name	Supervisor's Telephone #
Mike Fraser A/Detachment Supervisor	604 824-3320

C. EMPLOYEE DATA (if applicable)

	Occupation Fishery Officer

D. ACCIDENT INFORMATION

Accident Location	Date and time of Accident	Number of hours on shift on this day before this accident.
Abbotsford Fish and Game gun range 4161 Lakemount Rd, Abbotsford, BC V2T 6Z6	May 12 2017 at 1300 hours	3 hours

Weather conditions at the time of the occurrence:

Indoor range

Description of Injury:

No injury

Was training in accident prevention given to the injured employee in relation to duties performed at the time of the hazardous occurrence?
Yes _____ No_____
Specify: No Injury but safety briefing was provided

No injury

E. INVESTIGATION OF OCCURRENCE

Description of what happened (please attach additional sheets if necessary)

On Monday May 15 during low light firearms training there was an unintentional discharge of Fishery Officer [redacted] pistol on the indoor range.

During a supervised **training** drill the officer unintentionally pulled the trigger of his pistol **resulting in a discharge**. He had the pistol in his support hand and was also attempting to grasp his flashlight with his support hand. He was using a technique that was not based on any instruction provided by firearms instructors. He was incorrectly attempting to accomplish a set drill. The gun was pointed in a safe direction, down range and upward. The round went thru a ceiling tile and passed thru the tin metal roof. Officer [redacted] new that his finger was on the trigger instead of on the frame of the pistol while he was conducting the technique and he knew right away what the cause of the unintentional discharge was. Range Officer Rob Harris came over and officer [redacted] holstered his firearm and informed Rob that he had his finger on the trigger while performing the technique and inadvertently squeezed the trigger as he seated the new magazine.

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In this section please identify personal, environmental and/or job/system factors:

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s.19(1)

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Nature & extent of property damage	Estimated Loss ($)
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L. INVESTIGATION DONE BY

Name of Manager or Manager Appointee	Telephone #	Signature
Mike Fraser/Rob Harris	604 824-3320	MIKE FRASER FEBRUARY 16th, 2018

Manager's comment:

Mike Fraser Comment:
As a firearms instructor we know that we have multiple safety measures in place to prevent injury during firearms training. The fact that Officer [redacted] pistol was pointing in a safe direction was the most important factor during this training as it clearly prevented a potential serious accident. This is something that line officers are able to observe in a low light environment and clearly Line Officer Clattenburg was able to maintain the safety of the individuals under his supervision by ensuring all firearms remained pointed in a safe direction. Officer [redacted] immediately new the cause of the unintentionally discharge and was forth coming in explaining this to the Range officer who then provided remedial training. I am satisfied that appropriate measures were taken in this situation.

Name of OSH Committee Member / OSH Representative	Telephone #	Signature

* Due to time delay OSH c.m. not completed reviewing or signing HOR

Gray, Trevor

From: Carlson, Mike
Sent: Friday, March 9, 2018 11:17 AM
To: Gray, Trevor
Subject: RE: Pacific Region HOIR - training incident at Abbotsford Gun Range in May 2017 (near miss)

Trevor:

A very close call indeed!!! Have you received the update yet?

Mike

From: Gray, Trevor
Sent: Wednesday, February 14, 2018 3:24 PM
To: Fraser, Mike <Mike.Fraser@dfo-mpo.gc.ca>
Cc: Sumi, Catherine <Catherine.Sumi@dfo-mpo.gc.ca>; Carlson, Mike <Mike.Carlson@dfo-mpo.gc.ca>; Redekopp, Herb <Herb.Redekopp@dfo-mpo.gc.ca>; Clements, Brian <Brian.Clements@dfo-mpo.gc.ca>; Harris, Rob <Rob.Harris@dfo-mpo.gc.ca>
Subject: Pacific Region HOIR - training incident at Abbotsford Gun Range in May 2017 (near miss)
Importance: High

Hi Mike,

I learned this afternoon that RTS did not complete the HOIR and subsequent investigation (other than what you and Rob initiated) for the incident at the Abbotsford Gun Range in May 2017 (Sherry confirmed with Rich). I have reviewed the HOIR that you initiated and would appreciate your help as follows:

-review the attached HOIR and consider my comments and update if appropriate. I recognize you are a subject matter expert but I may see things through a different lens
-update the wording to reflect 3rd person so we are clear who was doing what role
-it indicates we took supplementary measures which were assigned to Rob. Can you elaborate in the document what they were and if they have been completed
- please include a sentence that confirms the appropriate representative from the Abbotsford Gun Range was notified and who this individual is
-update the property damage estimate (I believe it was around $1600)
-sign the HOIR in the appropriate box (if Rob was assigned to investigate by the Manager then he should sign it)
-return to me to complete the Manager comments section. As Regional Firearms Officer I think it is appropriate for me to comment.
-provide me the name of the Health and Safety representative for the Chilliwack office. I will send it to them for their comments and signature once I provide my input.

This is somewhat time sensitive so I would appreciate it if you could have this updated and returned to me by Feb 21st.

Thanks for your help on this.

Trevor Gray
Chief of Recruitment, Training and Standards
Fisheries and Oceans Canada
Conservation & Protection – Pacific Region

401 Burrard St.
Vancouver, BC

Office (604) 775-8008
cell (778) 884-1349
e-mail: trevor.gray@dfo-mpo.gc.ca

Fishery Officer Career Information http://www.dfo-mpo.gc.ca/career-carriere/enf-loi/training-formation-eng.htm

From: Gray, Trevor
Sent: 2018–February-14 9:20 AM
To: Clements, Brian <Brian.Clements@dfo-mpo.gc.ca>
Cc: Arbo, Andrea <Andrea.Arbo@dfo-mpo.gc.ca>
Subject: Pacific Region HOIR - training incident
Importance: High

Hi Brian,

We had a firearms training incident in May of 2017 that I have just learned may not have been reported up through proper channels. Are you able to confirm if your office received a final copy of the investigation for me? The HOIR that I tracked down hasn't been investigated fully (see attachment).

If this incident wasn't reported properly, I will re-start the investigative process immediately.

Thanks for your help.

Trevor Gray
Chief of Recruitment, Training and Standards
Fisheries and Oceans Canada
Conservation & Protection – Pacific Region
401 Burrard St.
Vancouver, BC

Office (604) 775-8008
cell (778) 884-1349
e-mail: trevor.gray@dfo-mpo.gc.ca

Fishery Officer Career Information http://www.dfo-mpo.gc.ca/career-carriere/enf-loi/training-formation-eng.htm

From: Gray, Trevor
Sent: 2018–February-12 9:20 AM
To: Bruinsma, Sid <Sid.Bruinsma@dfo-mpo.gc.ca>
Subject: Pacific Region HOIR - training incident

Hi Sid,

s.19(1)

Attached is the HOIR from the May firearms training incident at the indoor range in Abbotsford. I will attempt to track down the final signed off copy by the OSH group.

Thanks,
Trevor Gray

Sent: 2018–February-12 8:54 AM
To: McDonald, Sherry <Sherry.McDonald@dfo-mpo.gc.ca>; Gray, Trevor <Trevor.Gray@dfo-mpo.gc.ca>; Sumi, Catherine <Catherine.Sumi@dfo-mpo.gc.ca>
Subject: FW: HOIR

Here is a copy of the HOIR dealing with the Abbotsford Range unintentional discharge before it was signed by Rich. Rob Harris was running the line and Dave Clattenburg was the assigned line officer during this incident.

Thanks

Mike Fraser
Fishery Officer
F.V.E. Detachment Chilliwack
Phone (604) 824-3320
Cell (604) 798-2622
Email: Mike.Fraser@dfo-mpo.gc.ca